ABSTRACT
        This document contains 24 papers. Keynote addresses
were given on the topics of autonomy for deaf adolescents and
parent-adolescent dialogue. A section titled "Demographic Profiles of
Deaf Adolescents in America" compares students in special schools
with mainstreamed students. A section on "Family Intervention and
Parent Education" includes three papers that cover preparation for
adulthood, treatment of the larger than family system, and rubella
babies as parents. "Transition from School to Work" examines
transition workshops for parents, the family's role in transition,
educational and occupational aspirations/attainments, and employers'
perceptions. "Approaches to Sexual Abuse Interventions and Suicide
Prevention" focuses on treatment of sexual abuse victims, sexual
health policies, suicide prevention, and intervention with suicidal
adolescents. "Strategies of Enhancing the Social and Emotional
Development of Deaf Adolescents" reviews the self-image of deaf
adolescents, consciousness-raising with deaf female adolescents,
adapting and evaluating social skills curricula, assessing language
competence, preventing substance use disorders, and inservice
training in residential schools. A section on "Approaches to
Substance Abuse Education and Prevention" describes self-help groups,
Gallaudet's student development approach, reality therapy, and
networking. (JDD)

Innovations In The Habilitation And Rehabilitation of Deaf Adolescents

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of Deaf Adolescents

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Selected Proceedings of the Second National Conference
on the Habilitation and Rehabilitation of Deaf Adolescents

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PREFACE

In 1985 the University of Arkansas Rehabilitation Research and Training Center on Deafness and Hearing Impairment (RT-31) was privileged to collaborate with a number of other outstanding deafness rehabilitation agencies and organizations in producing the monograph, <u>The Habilitation and Rehabilitation of Deaf Adolescents</u> (Anderson & Watson, 1985). The publication presented information that highlighted the proceedings of the first National Conference on the Habilitation and Rehabilitation of Deaf Adolescents. In addition to identifying and describing the special characteristics, problems, and service needs of deaf adolescents and their families, the papers reported on efforts underway to meet the identified needs. One of the primary needs articulated was for additional biannual conferences to further develop and stimulate improved "standards of care" in service, training, and research.

The current publication consists of selected papers that were presented at the second National Conference on Innovations in the Habilitation and Rehabilitation of Deaf Adolescents. It addresses a need--identified by participants at the previous (first) conference--to report on innovative approaches, techniques, and programming that have been demonstrated to be effective in use with deaf adolescents and their families. Hopefully, the reader will find this book serves as one more meaningful step in the profession's progress toward excellence in services for the deaf adolescents we serve.

To quote from the charge that both the first and second national conferences addressed:

> The years of adolescence (i.e., those from age 12 through 20) bring forth many concerns for youth, parents, educators, rehabilitation counselors, legal and social service providers, and society in general. These concerns arise because the transitional period of growing from childhood dependency to adulthood is often a troublesome period, marked by numerous developmental crises such as physical and emotional change, quest for independence, uncontrolled external influences, and peer group pressures. For deaf youth, the problems of adolescence are further magnified by the inherent problems of communication which can preclude or interfere with the delivery of appropriate interventions. There is much evidence in published literature (and in the papers contained in this document) that problems of emotional disturbance, substance abuse, juvenile delinquency, physical and sexual abuse, employment difficulties, and a host of other social problems are increasing in incidence among deaf adolescents. Thus, the underlying question that stimulated national interest in this conference was, in what ways can the field of deafness effectively respond to the pressing needs of deaf adolescents? (Anderson & Watson, 1985, p. 3).

In response to this charge, the second national conference convened a group of 58 nationally recognized authorities representing a variety of professional disciplines in the area of deafness to address 10 different topical areas ranging from transition from school to work, to residential programs for

adolescents with emotional/behavioral problems; from suicide prevention pro-
grams to substance abuse interventions; and from social skills training inter-
ventions to parent education and counseling. This distinguished group of pre-
senters were selected from among a much larger number of respondents to the
conference's call for papers. These presentations included 34 ninety-minute
individual concurrent workshops, three keynote presentations, a host of poster
sessions and a film festival on substance abuse sponsored by the Gallaudet
University National Academy.

In retrospect, the document is an attempt to highlight selected pro-
ceedings from this four-day conference which attracted over 350 profes-
sionals, parents, and consumers from across the United States and from as far
as Alaska and Canada. The papers presented in this publication are organized
with seven major sections. Section One includes two outstanding keynote pre-
sentations, one by Kay Meadows-Orlans and the second by Hilde Schlesinger.
Both of these keynote presentations contributed to establishing a major theme
for the conference which was aptly stated by Dr. Meadows-Orlans in the
following statement,

> "Development of autonomy is discussed as the primary goal for
> adolescents. . . Autonomy is necessary if adolescents are to enter
> successfully the adult world of work and develop meaningful skills.
> Autonomy is necessary if adolescents are to enter sucessfully the
> adult world of love and develop satisfying relationships leading to a
> cohesive and rewarding family life. Autonomy is noted in a willing-
> ness to accept responsibilitiy for oneself and the consequences of
> one's 〈 tions. Autonomy is impossible without a firm sense of iden-
> tity and self-acceptance" (pp. 1-2).

The subsequent sections, two through seven, include papers which describe
innovative habilitation and rehabilitation approaches, interventions, and
program models designed to contribute to or facilitate the development of
autonomy in deaf adolescents within a variety of settings such as tne home,
school, work, and community. Of special note is section seven which addresses
the topic of substance abuse education and prevention. Through collaborative
efforts with Gallaudet University, a series of nine individual concurrent ses-
sions on the topic of substance abuse education and prevention were sponsored
by its National Academy. Four of the papers submitted for publication are
included in section seven.

It is hoped that this document, at least in part, captures the spirit of
this second national conference and that it provides a framework to enable the
field of deafness to even more effectively respond to the needs of our most
valuable resource, adolescents with hearing impairments.

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ACKNOWLEDGEMENTS

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AUTONOMY FOR DEAF ADOLESCENTS:
FACILITATIVE ENVIRONMENTS

KATHRYN P. MEADOW-ORLANS

Development of autonomy is discussed as a primary goal
for adolescents. Dependency may be inherent in the con-
dition of deafness because the social and physical world is
organized around the needs of hearing persons. In addi-
tion, autonomy can be particularly difficult for deaf ado-
lescents to achieve because of the cumulative effect of
earlier protectiveness of parents and teachers. Ways of
facilitating autonomy for deaf adolescents at home and at
school are discussed. Special emphasis is placed on the
need to provide opportunities for autonomy in the world at
large so that deaf adults can exercise their skills.

My presentation today is built on the theme that there are three primary
tasks for adolescents. The first is the development of autonomy; the second
is achievement of Independence; the third is self-determination. Another way
of expressing this thought is to say that adolescence, like real estate, can
be reduced to three important principles. In real estate, these are location,
location, and location. For adolescence, they are autonomy, autonomy, auton-
omy. Autonomy is necessary if adolescents are to enter successfully the adult
world of work and develop meaningful occupational skills. Autonomy is
necessary if adolescents are to enter successfully the adult world of love and
develop satisfying relationships leading to a cohesive and rewarding family
life. Autonomy is rooted in a willingness to accept responsibility for
oneself and the consequences of one's actions. Autonomy is impossible without
a firm sense of identity and self-acceptance.

As we begin our meetings and discussions for this second national con-
ference on habilitation and rehabilitation of deaf adolescents, it seems
appropriate to review some of the papers from the first conference which

touched on my topic. It was no surprise to find many papers in the pro-
ceedings of that conference related to autonomy. For example, Schlesinger and
Acree (1984) stress the importance of dialogue for the development of an
autonomous adolescent. They suggest that the "successful" adolescent
experienced two-way rather than one-way conversations with parents in the
early years--that is, dialogue rather than monologue--and that an early sense
of personal power evolving from this parental interaction was related to later
effectiveness. Lytle and Jonas (1984) contrast the adjustment of high school
students in a new environment in terms of their opportunities for independence
in former school settings. Mendelsohn and Fairchild (1984) discuss three
stumbling blocks forming barriers to independence in deaf adolescents. They
say that two of those barriers--language and education--inevitably lead to the
third: inexperience. As parents, they are keenly aware of the fact that ado-
lescents' concerns for developing independence are sometimes a mixed blessing.
Straining toward autonomy can be exhilarating for children but painful for
parents. Aldridge (1984) described her contacts with some parents who dread
their adolescent's separation from the family, "particularly if they felt
their youngster might choose the deaf world" (p. 126). The Fitz-Gerald's
(1984) illustrated the absence of information about sex on which deaf children
might base independent decisions in that area. Miner (1984) expanded on that
in her consideration of general health care. She said, "Managing one's body
in illness and health, negotiating a hospital system, being responsible for
medication and appointments . . . are all ways in which one assumes respon-
sibility for one's self in the larger world. It is only one small step along
the road to independence, but it needs to be taken" (p. 166). These are only
a few of the many examples of concern about autonomy by participants in the
first national conference.

Deafness and Dependency. We all know many of the reasons for the dif-
ficulties deaf adolescents have in developing autonomy, and in putting aside
dependency on others. Nevertheless, I would like to make two points that are
particularly relevant to my theme today. One is related to Hilde
Schlesinger's theory about the importance of feelings of powerlessness in the
development of dependency and helplessness in members of many disadvantaged
and handicapped groups. She contends that many individuals who have little
power to influence their own environments, to create their own destinies,
become defeated and stop making an effort to take responsibility for them-
selves. Another part of her theory relates to behaviors that are charac-
teristic of many hearing mothers of deaf children--behaviors that are labelled
"intrusive" and "controlling." Schlesinger suggests that these parental
behaviors have their source in a sense of powerlessness: on the part of
parents who "have brought forth a child with a disability that they cannot
directly influence" through the usual communicative channel (Schlesinger,
1985:105). This is a persuasive argument, and provides an explanatory theme
for some of the difficulties of deaf adolescents.

Carol Erting has made an insightful point about the "dependency
constraint" for deaf persons which I believe is complementary to Schlesinger's
theory of powerlessness. She says the necessity for total reliance on the
visual mode produces a set of constraints on deaf people that are quite apart
from personality factors (or that interact with personality factors) to
increase dependency. Since the world is set up for persons who hear, many

everyday needs--to say nothing of emergency events--are geared to the auditory
sense. Erting says that:

> For most deaf people born to hearing parents . . . dependence begins
> at birth. Their dependence on people who hear has its roots in the
> emotionally powerful and influential experiences of early childhood
> and the parent-child relationship. Dependence continues in the
> spheres of education, religion, employment, and in the acquisition of
> goods and services provided and controlled primarily by those who
> infrequently confront or even think about deafness as a life
> experience . . . (deaf people) continue to find their fate dependent,
> to a large extent, on the willingness of hearing people to interact
> with and accommodate them (Erting, 1985:227).

Although this seems to me to be an extremely illuminating insight, and
(like many brilliant observations) obvious once it has been made, there have
been some interesting responses to Erting's idea. Deaf people generally are
prepared to nod in agreement: yes, this describes an important part of their
life experience. However, many hearing people who serve as "brokers" for deaf
persons in the hearing world--many interpreters, for example--find the notion
quite unacceptable and argue bitterly that it is not true that deaf people are
forced to dependency by the structure of the hearing world. Perhaps it is
more than a coincidence that interpreters find this idea difficult, since the
need for an interpreter in public situations is certainly one example of
Erting's dependency constraint.

The point of this part of my discussion is that there are two parts of the
thrust toward dependency for deaf people: one part may come from early and
continuing experiences that neither foster nor allow the development of auton-
omy as a "habit" or as a "personality characteristic." The other part of
dependency is that which is embedded in the social structure and which is
forced on deaf people even if their characters or personalities are strongly
autonomous. I want to address both of these aspects of autonomy in my remarks
today. That is, what kinds of environments encourage the development of
autonomous deaf adolescents, and second, what kinds of environments allow
autonomous deaf persons to exhibit and utilize their independence after it has
developed?

ENVIRONMENTS: HOME, SCHOOL, COMMUNITY

Encouraging Autonomy at Home. All parents of adolescents have difficulty
making decisions about how much independence to allow and what limits must be
set. For the hearing parents of deaf adolescents, these decisions are made
more difficult by the frequent absence of fluent communicaton between parents
and child, and by the probable immaturity of deaf adolescents compared to ado-
lescents without hearing impairments. The importance of home communication
for the development of many skills has been documented again and again. We
have been told by many researchers and practitioners that deaf children
growing up in deaf families where communication is easy and fluent have an
advantage over deaf children growing up in hearing families. I do not intend
to dwell on this aspect of instilling autonomy at home. Rather, I would like
to emphasize another difference that may exist in deaf and hearing families of

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deaf adolescents. This is a recognition of the urgent need of deaf people for information, and the lifetime of experience with deafness that helps deaf parents to understand more fully the gaps and difficulties in acquiring information and experience which is an inescapable concomitant of deafness.

Again, Erting's long-term anthropological study of interactions between parents and educators in a school for deaf children provides insights that are pertinent here even though her study involved parents of preschoolers. The school in question used a mental health model for working with parents, both deaf and hearing. Opportunities were provided for weekly meetings during which parents were encouraged and expected to discuss their feelings about deafness and their problems in dealing with a deaf child. The deaf parents became very impatient with this approach and insisted that their primary need was not for counseling but for information.

(This) was a result of the lifelong difficulty they had experienced gaining access to everyday knowledge, much of which is available only in auditory form. They know that information and knowledge were necessary prerequisites for daily decision-making and that the net result would be more control over their own lives and those of their young children (Erting, 1985:214).

For the same kinds of reasons, the deaf parents were insistent that the curriculum used by the school did not include many of the practical skills most important for their children. They showed a preference for deaf teachers, partly because those teachers were willing to deviate from the curriculum

to teach children what they needed to know in order to survive in the world. They needed to know such things as how to buy a pair of shoes: that they had to ask for a specific size, and how to ask in an acceptable way . . . they also needed to be taught how the system works and how to express their desires and questions without offending hearing people (Erting, 1985:238).

One deaf mother recalled the helpfulness of personnel in her residential school who had been particularly helpful in telling her not only about how to acquire a driver's license, but also in telling her that it was a requirement before driving a car on the public highways.

For a recently reported study (Klansek-Kyllo & Rose, 1985) comparing hearing children with deaf children (all with hearing parents) parents were interviewed for their responses to the Scales of Independent Behavior (Bruininks, Woodcock, Weatherman & Hill, 1984). The deaf children were found to be comparatively deficient on the cluster of scales labelled "social and communication skills." Also, as we would expect, deaf children scored significantly below the hearing children on subscales labelled social interaction, and language comprehension.

Of more interest for the present discussion is the fact that deaf children were also deficient on subscales labelled "money and value" and home-community orientation." These two scales include items such as making arrangements for a dental appointment, filling out an application form for a

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savings account, budgeting and banking skills, moving about the community by foot, bike, bus, or car, and utilization of facilities in the community such as the post office.

For hearing parents, we know that a combination of protectiveness for their handicapped child and uncertainty about degree of comprehension on the child's part leads to an unwillingness to provide opportunities for independence, beginning in the preschool years. This kind of discomfort in the parents, and the cumulative effect on the deaf child can spiral so that in adolescence both child and parents can find themselves caught in a vise of cumulative helplessness and inexperience.

For parents who have been reluctant to allow their deaf preschooler to roam around the house without supervision, who have then been reluctant to allow their deaf eight-year-old to cross a street in a quiet residential area, who have been reluctant to send their deaf ten-year-old to the neighborhood store on an errand, the prospect of the deaf adolescent facing the dangers and difficulties of the adult world is quite distressing.

Researchers investigating locus of control in deaf adolescents reported that those with deaf parents were more internally controlled. That is, they believed that events were controlled by themselves rather than by others or by fate. It was suggested that deaf parents placed greater emphasis on self-reliance than did hearing parents. "Certainly such a child-rearing practice would encourage greater independence, leading to a more successful manipulation of the environment and a belief in personal rather than external control" (Koelle & Convey, 1982:778). It is both more difficult and more important for parents of adolescents to provide new opportunities for autonomy. When communication is difficult it may be a great temptation to give up and let the peer group run its course.

It is difficult to improve on the suggestions made by two parents who spoke at this conference two years ago. Mendelsohn and Fairchild urged that hearing parents continue working to improve their communication skills and their communication with their deaf children, and that they continue to press school personnel and rehabilitation counselors to work with them to encourage autonomy in their adolescent children. The concern they expressed about the effect of SSI payments on the future autonomy or sense of dependence in young deaf people is well taken. The question of how to balance appropriate help with overprotection leading to an expectation of life-long community support is not an easy one to answer, but it needs to be addressed. For parents to continue to press school administrators and community agencies to include the family in their planning for adolescents, and to combine with other parents in their efforts to foster autonomy will help to make the home an environment that facilitates growth and independence.

One final thought, which again echoes a point made by Mendelsohn in 1984: hearing parents are not alone in experiencing difficulty fostering independence for deaf adolescents. Just as there is tremendous variation in individuals, there is great variation among families. Hearing parents with hearing adolescents will be quick to tell us that finding a balance between granting independence and maintaining limits can be difficult and exhausting. Fluent

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communication is not the only ingredient for an environment that facilitates autonomy. We need to make sure that we appreciate the strengths in all families and that we do not make assumptions about individual family units based on group research data. There are many deaf families that find granting independence very difficult; there are many hearing families that successfully traverse the trauma of adolescence.

Encouraging Autonomy at School. Just as there are wide variations among families of any given "type" in provision of opportunities for independence, so are there wide variations among schools of any given type in this regard. One important point to make here is the degree of change that has occurred in the willingness of school officials to encourage autonomy on the part of students. This is particularly true in residential schools. Deaf adults today who return to their alma maters barely recognize them because of the amount of freedom students enjoy. To illustrate, I would like to read from the policy statement of one State residential school for the deaf, considered to be quite progressive. This was policy in the year 1970.

> Dating, as such, is not permitted. The school provides as many opportunities as possible for boys and girls to mix socially. These activities are necessarily group activities since there are a limited number of staff members to provide supervision . . . No doubt there are many older students capable of behaving themselves at all times in unsupervised boy-girl relationships . . . There is equally no doubt that there are students who would not be capable of behaving themselves at all times . . . Unfortunately, there is no sure way of determining to which group any given student belongs (cited in Schlesinger & Meadow, 1972:147).

School policy has come a long way since this was written. Today there is a greatly heightened awareness of the importance of opportunities for autonomy and self-decision, but also a sophistication on the part of administrators about ways of providing these opportunities.

Policy decisions, efforts of dormitory counselors and classroom teachers to change the social environments over which they preside, and actual programmatic interventions all are part of efforts to facilitate autonomy in deaf students today.

Some interesting programs include one called "language for adaptive interaction" or "adaptive dialogue" (Gawlik, McAleer, & Ozer, 1976). The developers had observed that the students, with limited speech and limited competency in language often "function as passive receivers in interaction with others." Frequently students did not have much control over the amount of input, its rate, or mode. They also observed that children with little capacity for adaptive dialogue tended to resort to defensive behaviors in the classroom, including changing the subject, disrupting the class, withdrawing and "turning off." The adaptive dialogue was presented in the form of a game with younger children, either by a school counselor or by the classroom teacher. The process begins when the student is given instructions to perform a task:

Student: I don't understand.

Teacher: OK.   How can I help you?

Student: (has seven choices):   Again, please; OR Again, slow; OR
           Write, please; OR Show me; OR Do it with me; OR Talk loud;
           OR Help me.

Teacher: Thank you for telling me.

Control of the environment through the use of language is a very important
element of psychosocial development, and one that escapes many deaf children.
This seemingly simple strategy is an effort to create an environment to
facilitate autonomy.   Wood has talked about responses of deaf children to
linguistic control by their teachers in the classroom.   He has illustrated the
effect that linguistic styles have in relieving children of opportunities to
control their environment (Wood, 1982).

Wood says that teachers who ask a lot of questions or tell children what
to say constrain the student's role in the conversation.   On the other hand,
teachers who tell the children about their own ideas or simply acknowledge
what the students are telling them leave the students free to participate on
their own level.

High control from their teacher goes hand in hand with short, often mono-
syllabic utterances from children.   It inhibits children from spontaneously
elaborating on the topic . . . and from asking questions . . . Children also
ask more questions, introduce more new topics and generally take a more active
role in the dialogue when teachers are low in control (Wood, 1982:89).

Enabling Autonomy in the Community.   The final environment to be included
in my discussion this morning is that of the wider community.   Adolescents are
looking ahead to the adult world from their sheltered positions in the family
and at school.   For deaf adolescents, the shift from these sheltered environ-
ments to those where they must assume responsibility as adults may be more
extreme than it is for hearing adolescents with more experience.   Although we
can hope that young deaf people are prepared to live and work independently
when their education is complete, it is important for parents, educators and
deaf community leaders to continue work toward opportunities for them to prac-
tice their independent skills.

There are any number of possibilities for changes in the organization of a
world arranged for the convenience and the capabilities of the hearing popu-
lation that would make autonomy more possible for those wholly dependent on
the visual sense.   Although we should not feel that the work is done there has
been enormous progress in the provision of environments conducive to autonomy
for deaf adults in the past 20 years.   By taking a brief look at these
changes, and how they have come about, we may get additional clues in how to
proceed for the future.

Here are some of the changes which seem to me to reflect "progress" in
provision of opportunities for autonomy for deaf persons:

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1. Increased numbers and kinds of opportunities for advanced education.

2. Increased interest in sign language.

3. 'ncreased availability of sign interpreters.

4. Technological advances leading to closed captioning of television programs, new telephone communication possibilities, computer communication, etc.

Many of these changes have come about because of concerted efforts in the deaf community, spearheaded by deaf leaders. These are the most valuable kinds of activities -- not only do they represent autonomous activity, I believe they have a "snowball" effect in supplying role models for younger deaf persons who can be proud of the leadership exhibited by members of their group. Thus, one way to encourage autonomy for deaf persons in the broader society is to support actions by deaf persons themselves rather than looking to hearing people to provide that leadership. One aspect of this increased leadership activity within the deaf community, and the growth of movements for "deaf pride" is an increasing militancy and a tendency to exclude hearing people from the inner circle. For those of us who do not have deaf children, this can be seen as a sometimes uncomfortable, but nevertheless welcome development. For hearing people who have deaf children, this can be a painful ordeal. Hopefully we will see increasing ways of maintaining autonomy while also maintaining important family and mutually beneficial ties with the hearing community in the years ahead.

The increase in opportunities for both undergraduate and graduate education in recent years is one of the most striking changes. Not too long ago, Gallaudet University was almost the only place where deaf persons might obtain postsecondary training. The creation of the National Technical Institute for the Deaf, the Leadership Training Program at California State University, Northridge, and at Seattle Community College are important additions. The most recent edition of College and Career Programs for Deaf Students published by Gallaudet University and NTID lists almost 150 postsecondary opportunities.

The role of Gallaudet University in progress toward autonomy for deaf persons should not be minimized. Despite the early paternalism (which sometimes continues) Gallaudet has served as the training ground and rallying point for many highly talented deaf persons. Many deaf Gallaudet graduates are among those who organized important educational, cultural, social, and practical activities; nurtured a sense of pride, self-esteem and group identification and provided leadership in the field of deaf education. I believe that the existence of Gallaudet as a separate or "segregated" institution led to later events providing deaf high school graduates a broader range of educational and occupational choices.

Much of the legislation and many programs on behalf of deaf persons has been advanced through Gallaudet channels. Sign language training programs have provided a growing number of interpreters, thus giving broader access to many services and activities for many deaf persons. Gallaudet University

itself is a microcosm of changes in attitudes about and opportunities for deaf persons. For example, in the late 1800's, Alexander Graham Bell testified before the U.S. Senate against establishment of a teacher training program for students with normal hearing at Gallaudet University on the grounds that the university would also accept deaf students into the program (Moores, 1982:22-23). Nevertheless, Gallaudet did not accept deaf students into the graduate school until the 1960's, a reflection of the speed with which changes have come in outlook and attitudes as well in opportunities.

Increasing Status of Sign Language. Enmeshed with the positive visibility provided by many deaf community leaders has been the increasing visibility of sign language in the U.S. Today there is hardly a junior college or adult education program that does not offer at least one course in sign language. Some high schools include sign language in the curriculum. Presidential candidate J my Carter used a sign interpreter during his nationally televised acceptance speech at the Democratic national convention in 1976. A number of universities accept sign language proficiency to fulfill a foreign language requirement for the doctorate degree. Many television stations employ sign language interpreters for locally produced TV programs.

How did these changes come about? The role of research on sign language, pioneered by William Stokoe and his colleagues, beginning about 1960, lent to American Sign Language a respectability it had previously lacked (e.g., Stokoe, Casterline, & Croneberg, 1965). Secondly, the work of Gerilee Gustason (Gustason, Pfetzing, & Zawolkow, 1972), Harry Bornstein (1982) and others in creating artificial, English-based sign systems helped overcome the resistance of hearing parents and educators to the use of sign language with younger children. Again, research on the use of sign language with various populations was a contributing factor to increased acceptance, as was the political activity of hearing parents who wanted sign as an option for their children.

Third, I would cite the work of the National Theater of the Deaf, which used American Sign Language, and was seen as an art form not only in the deaf community, but by hearing theater-goers as well. The NTD, of course, was funded by the federal government, through the creative leadership of an energetic and sympathetic friend of deaf people, Mary Switzer.

Another development contributing to change was the passage of Section 504, requiring equal access to public buildings and functions for all handicapped groups, which was interpreted successfully by deaf people to mean that interpreters must be provided for them. Organizations of deaf people joined together with representatives of other handicapped groups to form a larger and more powerful lobby to effect this law.

Each of these developments has contributed to increased public knowledge, acceptance, and visibility of sign language which in turn leads to a greater acceptance of deaf people and to a general climate of opinion allowing for independence and autonomy for deaf individuals. It is these kinds of developments which must continue to take place if there are to be incerasing opportunities for autonomy for deaf adolescents as they grow toward adulthood. The reason for cataloging past progress at some length here this morning is to

Illustrate the interaction and the interdependence of many strands leading to social change. I see, in the recent past, the strands of increased opportunities for education, growing leadership by deaf people of deaf people, lobbying for legislative progress, research in a variety of areas, a spiral of achievement leading to more achievement. Of major importance is the ability and the willingness of deaf people to lead the struggle for themselves, but also their willingness to accept the support of hearing parents and friends in their fig... for more autonomous participation in social and community life.

All our efforts toward providing environments which facilitate autonomy in deaf adolescents are eventually aimed at a single goal of enabling those adolescents to function independently, productively, and happily in their communities as they reach adulthood. A top priority, then, should be working to prepare an accepting community which will receive the contributions they will be ready to make.

(Some material in this final section was adapted from Meadow-Orlans, 1986).

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DIALOGUE IN MANY WORLDS: ADOLESCENTS
AND ADULTS-HEARING AND DEAF

HILDE S. SCHLESINGER

"tell me how bear you so comfortably the arrogant conduct
of maddening youth? Had I too not once behaved unbearably,
They would be unbearable in truth."

Goethe

ADOLESCENCE THROUGH THE CENTURIES

Adults remember their past adolescence with joy, pain, and amnesia; they
view their present adolescents with joy or with envy for their beauty,
freedom, strength, and opportunities. They usually heed the advice "Adults
must face it, adolescents are here to stay," (Anthony, 1969) but they do so
with enough ambivalence that adolescents have usually been given a bad name.

Socrates, 2500 years ago, commented on their love for luxury, their
demonstrations of bad manners, their contempt for authority and disrespect for
adults, he complained about their hanging around gossiping, monopolizing con-
versations, tyrannizing their teachers, and eating gluttonously.

Anna Freud captured the extremes of ambivalence presented by adolescents:
they see themselves as the center of the universe and as the sole object of
interest, yet they are never more capable of self-sacrifice and devotion.
Passionate love relations are as abruptly started as broken; the youth are
equally possessed by enthusiasm for life in the community and a longing for
solitude. They can demonstrate submission and blind obedience to a chosen
leader or defiant rebellion to any authority. Selfishness and materialism
alternate with idealism, esthetics with sudden, instinctual, primitive
indulgence, lighthearted optimism with black pessimism, and indefatigable
enthusiasm with apathy (Freud, 1964 cited in Ekstein, 1973).

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Anthony focused on the conflicts: "The adolescent will be seen as a victimizer and victim, as dangerous and endangered; as sexually rampant requiring restraint and as sexually inadequate needing encouragement; as emotionally maladjusted crying out for treatment and as emotionally free emitting a breath of fresh therapeutic air onto stale adult conflicts; as an enviable object to cut down and as a repository of the adult's unfulfilled ambitions to be built up; as a redundant family member to be extruded with as much haste as decency will permit and as a lost object to be mourned in passing" (Anthony, 1969, p. 55).

THE WORLDS OF ADOLESCENCE

The dictionary states that adolescence means becoming an adult anywhere from puberty to maturity, thus including all chronological and many psychological adolescents Some parents, some adolescents intransigently accept and live only in one world and exclude all others. Ideally, all parents and adolescents live in two worlds, in the world of adolescence and that of adulthood. Ideally, if parents or children, or both, are also deaf they will live in four worlds, adding the world of hearing and the world of deafness.

THE TASKS OF ADOLESCENCE

The tasks of adolescents are complex. They are to master their past in the present and to become ready for their future. They are to achieve "An intact self system [which] is achieved when gratifications from the appropriate experiences and mastery of tasks of any developmental period produce adequate self-esteem" (Cohen & Balikov, 1974, p. 220). They are to become emotionally sound, ethically responsible, and cognitively rational human beings with the human characteristics of commitment, loyalty, and fidelity. They need to work through developmentally appropriate conflicts and learn to regulate more and more of their lives.

They need to cope with the new sensations, new desires, and fantasies surging at puberty. Coping refers to both control and self-regulation and free expression of sexuality and aggression when appropriate. Aristotle indicated that, "Anybody can become angry-that is easy; but to be angry with the right person, and to the right degree, and at the right time, and for the right purpose, and in the right way-that is not within everybody's power and it is not easy." A similar phrase might be forged for sexuality.

Typical adolescents need to define, redefine, and refine the sense of self. We witness at adolescence a second step in individuation; the first one having taken place toward the end of the second year. In both there is a fateful distinction of self and non-self. The boundaries of this self need careful scrutiny as the archaic fears of engulfment or abandonment resurface even in youth who have traversed the first crisis successfully. The "adolescent is caught between the past and the future, between childhood and adulthood, just as the infant is caught between a symbiotic relationship and autonomy" (Deutsch, 1944 cited in Masterson, 1976, p. 48).

In adolescence, youth resist, rebel, and experiment in order to define their self, their very individuality. After each experiment, each resistance

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or rebellion they incorporate or extrude some aspect of individuality. Each youth now says, "'This is me or mine', or 'This is not me' [which] represents an important step in the achievement of individuation and in the establishment of autonomy; at an earlier age, it is condensed into a single word-'No'" (Blos, 1962, p. 12). The child's early self was simple and mirror-like; it was defined by others. The adolescent's self is a kaleidoscope of brilliant, dancing fragments of stained glass coming from numerous models and experiences. New fragments are discovered, extruded, reintegrated and represent shifting values, ethics and goals.

In early adolescence, there is near total preoccupation with independence and autonomy. Once this urgency is diminished, other concerns emerge: commitment to self, to friends and intimates, to goals, to the wider community, and to posterity. Many parents breathe a sigh of relief: finally the quest 'or autonomy is associated with appropriate responsibility. In general, attitudes towards the self include a willingness to be one's self, an effort to become more truly one's self and a conviction that one's self is worth being (Joint Commission, 1973, p. 222).

Adolescents observe the world around them with critical scrutiny and with a new range, agility, flexibility and adaptability of mental processes leading to increased ability for systematic thinking, and to the construction of ideologies, utopias, and models of reality. They develop a greater sense of historical perspective with increasing saliency for the distant past and the far-flung future.

During the process of observing the world they occasionally find radical discrepancies between parental edicts and parental behavior. Such discrepancies have been associated with delinquent, asocial behaviors (Bettelheim, 1985). Adolescents travel from compliance or rebellion, from the intransigent rule-bound conscience of childhood to a more tempered conscience, a more articulated and complex hierarchy of values, and an interest in becoming "a-best-self."

Adolescents need to know that the present is for their benefit, that usefulness will be defined by their terms, that their plans for their future are theirs alone and are not made by others. Unless their decisions become the accepted alternatives and those of others are precluded, the goals of others will be fought. Adolescents' commitment to tasks results in achievement of competence in work and play with or without full societal approval. As adolescence ends, the gap between grandiose purpose and puny accomplishments that characterizes many adolescents is narrowed, and the adult is now able to turn to the fulfillment of specific tasks.

Once identity is established, intimacy can follow. New relationships, new expectations will become crucially important to the adolescent and will reveal the "impossibility of achieving within [the] family any complete or lasting satisfaction of . . . new impulses, values and cognitive abilities [which] serves to propel the adolescent away from . . . family toward friends, peer groups, and-eventually-toward adulthood" (Joint Commission, 1973, p. 219).

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THE OPPORTUNITIES

Whether opportunities will be available to youth as a whole or to any particular youth depends on historical times. Will there be limitless opportunities forcing a difficult choice or will there be condemnation to rejection, inferiority, and exclusion due to individual or group scapegoating? The latter may force the youth to internalize the negative ascriptions made by the majority culture or to lash out violently against them.

SUCCESS OR FAILURE

Will there be success or failure in adolescent development? Much depends on the successful achievement of earlier developmental tasks. However, adolescence, unless irreparably flawed, can repair formerly flawed development. Successful passage through adolescence is promoted by opportunities for achievement and is undermined by forces that convince youth of worthlessness and inadequacy or that deprive them of realistic avenues for achievement, enjoyment and dignity.

The healthy adolescent, as summarized by Bowlby from varying studies (1973), demonstrates a simple directness of developmental pathways, a gradualness of changes in the growth of personalities and in the environment in which they have grown, and by an almost complete absence of stress, conflict and disappointment (Grinker, 1962 cited in Bowlby, 1973, p. 347). The best adjusted students in another study, "were plainly having the best of two worlds, being self-reliant in college yet enjoying increasing intimacy with parents during their vacation."

Others were not that fortunate. Some are "holding together like orphans in a storm, merely playing at the game of maturity . . . [while] others fail and remain symbolically attached to their families, through the fantasied family" (Williams, 1973, p. 326). Some join cults in an attempt to ease separation-individuation from their symbiosis. Others can only say 'yes' to what feels good, 'no' to whatever lowers self-esteem. A 'maybe' doesn't exist because they live exclusively for the moment (Blos, 1976).

Some adolescents grow distant or hostile to their parents, while others show "little ability to stand on their own feet or to organize their own lives" (Hamburg and colleagues, 1963 cited in Bowlby, 1973, p. 349). Psychopathology develops and yet other adolescents demonstrate findings similar to those described in 51 borderline adults (Grinker, et al., 1968 cited in Masterson, 1973, pp. 243-244): defects in affectional relationships, absence of indications of self-identity, with depressive loneliness and anger as the main or only affect. The psychological features of borderline youth, as described by Masterson (1980), include six overwhelming feelings: depression, anger, rage, fear, guilt, passivity and helplessness, emptiness and void.

Some of the youth have given up attempts at relationships but continue to react negatively towards the environment. Others move towards or away from contact with others and do so incessantly, angrily or with depression. Some not only give up on relationships with others but on identity itself; they sit in an empty world, passively awaiting cues from others. Lastly, some seek the lost symbiotic relation; their depression is deep.

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Another failure, less noxious than the one above, occurs when parents skip a vital, nonverbal developmental phase at the time of the establishment of primary identity (Herford, 1969). This refers to the body sense, the primary body image, when the physical relationship with mother and the sense of orientation in the world of space are achieved. This development precedes the verbal stage and encompasses many human skills which precede skills in language and speech. Many of us think primarily with our bodies and hands and others of us are able to shift gracefully from skills in the verbal and nonverbal area. This is more true of Americans than of old-fashioned European intellectuals who boasted about their refusal to use hammer and nail, even at times of great need. Modern youth is more able to combine verbal with the nonverbal skills of elementary drama, mime, painting, pottery, and craftwork. Skills in these latter forms of expression may be described as physical literacy, and must precede verbal literacy or its potential atrophies. Two unfortunate outcomes spring from vicissitudes in this development. "The verbal stage must be approached through the nonverbal; as a result of omission, or faulty timing, many young people leave school crippled in the capacity to use their nonverbal talents and are cured of any desire to learn. They have opted out from education and are unable to use leisure creatively. Frustrated in communication, it is not surprising that they show aggression, passivity, or delinquency. On the other hand, many highly verbal children are often channeled too soon away from nonverbal modes of expression. Verbally literate, they are often physically illiterate or even dumb (Herford, 1969).

This anxious insistence on verbal skills occurs frequently with hearing parents of deaf children. Sadly, this early emphasis on verbal, or vocal skills for deaf children may rob some of physical literacy, just as the pessimism regarding their verbal skills may rob some of verbal literacy.

Some other deaf adolescents resemble disadvantaged youth described by Kohen-Raz (1974), who found that their major sources of maladaptation were an external sense of control, a cognitive misconception of social and physical reality, and difficulties coping intellectually with the tasks and challenges of modern social and vocational life. The lament that follows may ring a bell in the mental health worker with deaf youth· their problems "cannot be solved by psychotherapeutic intervention, unless in addition, and perhaps mainiy, . . . cognitive handicaps are treated or eventually prevented" (Kohen-Raz, 1974, p. 153).

THE DEVELOPMENT AND TASKS OF PARENTS

An intact self-system is achieved when gratifications from the appropriate experiences and mastery of tasks of any developmental period produce adequate self-esteem (Cohen & Bolikov, 1974, p. 220). Mature love is achieved when the motivations and differences of others are respected without being experienced as an assault on self-esteem. Both parents and adolescents are traversing a developmental stage, it is to be hoped--a different one. Can parents accept divergent developments with grace, can adolescents evaluate parental differences with equanimity?

The ability to experience differences from others with equanimity appears to be related to a healthy self-esteem. Bertrand Russell (remembered from a

radio program long ago, but filtered through memory) stated that "if I think that I am a beautiful peacock, I can appreciate the beauty of other peacocks around me. If I don't see myself as a beautiful peacock, the beauty of others will repulse me." The ability to accept the autonomy and growing strength of others (including one's chi'dren) is related to a sense of autonomy and control. Russell could have added "if I see myself as weak, it will threaten me to see the power of others." This is important because the core of autonomy achieved by adolescents is influenced by their parents' expectations. An adolescent . . . perceived as sick, incompetent, too weak for life, immaturely dependent, too insecure . . . will become more easily paralyzed and deterred from separating himself than [one who] is seen as bad, mischievous, and trouble making. "Perceptions of 'badness' interchange, although implying dire anticipations of future failure, give the adolescent leeway for separating himself from his parents via rebellion and defiance" (Stierlin, 1977, p. 185).

In the first separation-individuation process towards autonomy some mothers cherished the infant's unfolding individuality, others were threatened by it. A similar dynamic occurs in the adolescent separation-individuation process and the threat of emerging individualit, again interferes with powerless mothers' ability to provide support. Children of these mothers have often learned early to disregard their potential for autonomy in order to keep the flow of maternal supplies intact. Later as adolescents, they perceive the threat that growth presents to their parents and react with confusion to this parental helplessness. They may demonstrate a desire to be expelled, to be forced to do things, all actions which eliminate their need to take independent actions that so threaten their parents. Frequently, a generational reversal occurs and helpless parents attempt to elicit succor from their helpless children.

Who are the parents who feel themselves to be beautiful, autonomous peacocks? It is likely those who had a positive solution of earlier developmental tasks. The earliest task for parents is to have the fortune or foresight to have chosen parents whose infancy was felicitous and who have built up an expectation of a benign environment. Such a background tends to facilitate early parental tasks which include the capacity to put the infant at ease, the ability to understand the infant's language and the psychological readiness to nurture and to promote growth. Somewhat later, in toddlerhood, parents in general need to support the action of their toddlers. Parents of adolescents need to affirm them in their development, to do so with support yet not to smother, to continue protective parenting, and to initiate letting-go.

Effective mothering includes the ability to perceive the needs of children and to legitimize them in spirit. In reality it can mean to fulfill needs if appropriate, to substitute if possible, to avoid multiple temptations and to refuse their gratification with explanations if necessary.

Empathic relatedness with growing children always "requires a reworking, a renegotiation of relationships" (Cohen & Balikov, 1974, p. 219). In latency, parental values and ideals are still easily imposed upon the child and parents are able to preserve a sense of power. In adolescence, parental ideals are no

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longer automatically cherished and all parents experience a loss of grace, a dethronement. Problems can abound. For example, in order for "empathic communication to remain stable, parents must be able to feel prideful even when the adolescent offspring is in a state of hostility" (Cohen & Balikov, 1974, p. 222).

Parents are affronted because adolescents want to be different from them. They forget that adolescents also want to be different from children, and that they are as "deeply engaged in delineating their identities as in revolting against authority" (Anthony, 1969, p. 76).

Some parents disengage and/or abdicate from their adolescents in order to flee from their feelings of helplessness which seriously lower their self-esteem (Cohen & Balikov, 1974, p. 221). Other parents engage in overprotection which ultimately serves the purpose of keeping the child dependent thus averting the separation trauma for all (Derdeyn & Waters, 1977). Some parents bind, tie, and lock the adolescent to the family. Binding can occur on the dependency level when parents indulge immature wishes (id binding), or in the cognitive arena (ego binding) where parents mystify children about their feelings, needs and wants. Lastly, parents produce "superego bound children who are prone to suffer intense primitive 'breakaway guilt' that operates often unconsciously and gives rise to acts of either massive self-destruction or heroic atonement" (Stierlin, 1977, pp. 212-214).

In general then, if parents of adolescents are living a life of general satisfaction, they will be able to enjoy the transition of their adolescents to adulthood. If they sense their own life a failure, they may envy the strength, beauty, freedom, and opportunities now available to their children. Parents and children will maintain a wary distance from each other, each defensively preoccupied with the other's shortcomings. They will be virtually lost to each other as emotional resources" (Derdeyn & Waters, 1977, p. 181).

How can parents react to provocative self-assertion accompanied by childlike requests for succor? How can they promote autonomy in a child deemed unready? How can they react to clinging, to silence or avoidance?

It may be possible to find creative ways to help parents to accept the ambivalence with which adolescents greet the world. Deafness, so far, was mentioned only briefly and the above vicissitudes apply to all adolescents and their parents. What additional difficulties may occur when the adolescents are deaf and the parents hearing?

"HEARING" AND "DEAF" WORLD AT ADOLESCENCE

The "majority" world for the parent who hears represents the well-known, the comfortable, the expected, the non-analyzed world of their childhood, and the world that they expected to share with their offspring. This same world for the deaf adolescent is associated with a myriad of feelings. It may be the envied world of those who can easily speak, or the fearful or despised world that punishes those who are different, or do not speak. This world may be seen as one of isolation, of absent dialogue, as a world that fosters dependence; it is a world to be fled or to be shared.

Usually when parents and children belong to different cultures, parents have elected, or have been forced, to leave their original homeland. Hope that their children will fare better in the new land has guided their steps. Most hearing parents did not choose deafness for their children nor do they know the deaf culture and the hope for their deaf children is tremulous. Although some hearing parents have tentatively explored the deaf world and have felt comfortable therein, many continue to see that world as one with a different tongue or hand, as one that steals their young. The deaf youth, however, on encountering the deaf world and its culture, frequently finds that s/he has, at last, come home especially if no genuine roots had taken ground elsewhere in earlier years.

Dr. Meadow referred to roots and wings as the greatest gifts that parents can provide their children. I should like to add that deaf children early on need roots from their hearing parents and from the deaf community. Stronger roots appear to lead to more effective wings with which to soar and fly from world to world. This seeming paradox also exists in infancy where more securely attached infants are more free to explore intensively and at greater distances from their mothers than their less securely attached peers. Some parents are able to provide strong roots to their children and to accept their children's roots in the deaf community.

ADVANTAGED PARENTS OF DEAF ADOLESCENTS

In our multimodal contact with hearing parents of deaf children as colleagues, patients or research subjects, we found that all of them had traversed the diagnostic crisis. Some of them, however, were advantaged, not so much through status as through the achievement of a quiet conviction that their children could develop roots with them and that the transmission of their values and language need not be inculcated with anxious insistence fed by doubt and fear of failure. They believed that deaf children could learn the skills of the hearing and the deaf world. These parents' background was generally felicitous, their generativity had been nurtured by earlier life experiences, and had not been eroded by experts as often happens with parents of children who are seen as needing special help (Schlesinger, 1987).

THE WOUND OF SOME HEARING PARENTS

On the other hand, many parents of deaf and other disabled children are wounded. The birth of their "different" child tugs at their self-esteem, and experts often usurp parental roles, and make them feel less in control. Anthony predicts major difficulty springing from a disability:

the ensuing narcissistic development of both parent and child. The injury to the parental self is severe and well out of proportion to the defect as assessed by others. The injury is inevitably transmitted to the child as part of his self development. Grandiosity is inevitable for the child who can injure the parents simply by existing. Thus the child who can make his or her parents feel impotent leads a grandiose self-existence (Anthony, 1976, cited in Buchholz & Mishne, 1983, p. 129).

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COMPETENCY AND JOY IN BOTH CULTURES

"Probably, the most powerful and convincing way to investigate any psychological phenomena is to try and change it" (Loevinger, 1976, p. 452).

Some of the saddest and most joyful phenomena observed in interactions of hearing parents and their deaf children were the interchanges at adolescence. Some were strained interactions with a paucity of meaning, others were rich and joyful dialogues, there were too many of the former and too few of the latter. Parents' and adolescents' comfort with and skills in the worlds of the other need to flourish.

For years I pondered, as do many others, what contributes to and what are the antecedents of deaf adolescents' academic success? The degree of hearing loss, intelligence, and the parental socioeconomic status did not fully elucidate the dilemma. Eventually, I remembered my participation in a study of adjustment of immigrant children, the outcome of which was shared with us: "The worst adjusted among you are those who totally reject either your old or your new country, the best adjusted of you are those who are positively oriented towards both cultures."

The ability to love and respect both the old parental world of origin and the new world, be it that of the immigrant child or the deaf child of hearing parents, augurs well for development. Reciprocal and circular relationships exist between the ability to love and be loved by society and the ability to acquire competencies valued in both worlds.

THE WELL FUNCTIONING PARENTS

We have previously indicated that there are parents of children who are fortunate, their background permits them to function well. There are also parents of deaf children who function well, in contrast to parents who function less well. Perhaps, they were not wounded as deeply or their wounds healed well. They felt in control of their parenting. What do they do differently? Which of their behaviors lead to competency and exhilaration and which lead to failure and despair for themselves and their children?

INGREDIENTS OF OPTIMAL LEARNING DEVELOPMENT

Feuerstein describes the optimal learning environment, one that will lead to high functioning in adolescence, as one where a responsive adult is interposed between the infant/child and the stimuli of the environment. This adult mediates and provides "the organism with modalities of selecting, focusing and grouping objects and events" (1977, p. 366). Vygotsky (1978) also stressed the importance of the guiding adult. He noted that there were functions in children "that have not yet matured but are in the process of maturation, functions that will mature tomorrow but are currently in an embryonic state . . . They could be termed the 'buds' or 'flowers' of development rather than the 'fruits' of development" (Vygotsky, 1978, p. 86). The guiding adult is aware of "the zone of proximal development . . . the distance between the [child's] actual developmental level as determined by independent problem

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solving and the level of potential development ac determined through problem
solving under adult guidance or in collaboration with more capable peers"
(Idem, p. 86). The guiding adults thus help the buds to develop. Less
guiding adults only address the fruits of development or go much beyond the
buds either causing boredom or avoidance. Other authors stress the need for
adult dialoguers (Bruner, 1983; Blank, 1975; Cazden, 1976; Vygotsky, 1978).

Academic performance for all children has long been postulated to be asso-
ciated with certain parental characteristics, usually those differentiating
advantaged and disadvantaged parents. Most of the crucial variables have been
related to socioeconomic variables such as income, maternal schooling, the
number of books in the home, and a number of other features more likely to be
found in the nome of the advantaged.

Not all socioeconomically disadvantaged mothers do poorly by their
children. Most modern authors believe that all parents want to do well by
their children. Sometimes they succeed and sometimes their very insistence on
success translates into drills with their children leading to failures. For
surely, minority mothers and mothers of deaf children do not contribute to the
failure of their children through disinterest as their vocal yearning for the
children's academic success attests. In minority mothers it is much more
probably attributed to a lack of access to resources, a possible ambivalence
about their culture and language, and an "interactional style that may not
prepare students for typical teacher/student interaction patterns in the
school" (Cummins, 1986, p. 22). In mothers of deaf children it may be
attributed to their yearning for sharing the same world as their children and
their ambivalence about the culture (with-its-different-language) that their
children may enter.

Recently, it has been stressed that parental dialogue features influence
the eventual cognitive outcome of their hearing children. However, many
questions have been raised as to the directionality of high quality maternal
dialogue, does a poorly functioning child elicit "low level" maternal
language, or does such language on the part of the mother produce a poorly
functioning child? A number of authors postulate that mothers of "different"
toddlers use more imperatives, fewer questions and fewer present, past and
future markers in order to accommodate to the child's delayed language
development, and therefore that the child's language provokes the mother's
language (summarized in Leifer & Lewis, 1983; Gleitman, Newport, & Gleitman,
1984).

An alternative explanation is that certain mothers promote optimal dia-
logue with children in general, even when confronted by children with delayed
language development. A number of authors believe that mothers with a sense
of power and ability are more likely to engage in optimal dialogue and that
the linguistic encoding of control stances may be responsible for their dif-
fering dialogue stances (Bee, Barnard, Eryes, Gray, Hammond, Spietz, Snyder, &
Clark, 1982; Brown & Gilman, 1972; Bugenthal & Shennum, 1984; Harris, 1983;
McClelland, 1975; Schachter, 1979; Slaughter, 1970, 1983; Tizard, 1974).

Power is a word that frightens. It has even been said that power corrupts
as it makes it "unnecessary for its wielder to respect and appreciate the

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needs of other persons" (Lord Acton cited in Stierlin, 1977, p. 65). Powerlessness surely corrupts more as the powerless make futile attempts to gain what seems an unobtainable sense of control. Indeed, I have postulated that powerlessness leads to disturbed parent-child power relationships and to controlling, non-mediating parental stances, which in turn impair the discourse aspects of their children's language acquisition, stifle their motivation, inhibit their autonomy and eventually result in their lower school performance (Figure 1)(Schlesinger, 1987).

Academic achievement wh ch is depressed by a sense of powerlessness is positively correlated with a sense of control. Twenty years ago, the Coleman Report (Coleman, et al., 1966) found that a sense of control of the environment within the child accounted for more of the variation in academic achievement than any demographic or school variable.

'. .ay, Cummins (1984, 1986) presents impressive data that empowering stances within society also promote academic achievement. Some striking examples are demonstrated by the differential academic performances of Finnish and Burakumin outcast students who fail in surroundings that define them as low-status, (e.g., Sweden and Japan) and succeed in surroundings that place them on a higher level: Australia and the United States, respectively (Troike, 1978, cited in Cummins, 1986; Ogbu, 1978). Black soldiers in post war Germany were more successful with the phonology of Bavarian German than they were said to be with the phonology of formal English. The lesser frequency of their exposure to Bavarian German was less important than the respect demonstrated to them by their local German women instructors/friends as compared to the frequent lack of respect on the part of the prior inculcators of formal English. This latter phenomenon may also account for the acquisition of hitherto unknown English syntactical features after deaf students left school (Schlesinger, 1982).

Parents who are seen as low-status by others can learn to not internalize this view. For empowering stances within parents are also crucial for the eventual academic success of their children.

An interesting relationship between a sense of control, self-esteem and respect for multiple worlds is spelled out by Cummins (1986). He summarizes the work of several authors, his own construct of "bicultural ambivalence," Ogbu's construct of "caste" (1978, 1982) and Feuerstein's construct of "disruption of cultural transmission to the next generation" (Feuerstein, Hoffman, Reimer-Jensen, & Rand, 1985). Cummins stresses that all these conceptualizations elucidate that "widespread school failure does not occur in minority groups that are positively oriented towards both their own and the dominant culture, that do not perceive themselves as inferior to the dominant group and that are not alienated from their own cultural values" (p. 22).

This theoretical orientation permits the depolitization of poor achievement, found in disproportionally high numbers, in certain groups as it eliminates any ethnic, cultural, economic or "disabled" pejoratives. It permits instead the concept of parents who live under pejoratives from self or others and who provide a similar communicative environment to their children. The status of being "advantaged" for children's academic success may therefore not

FIGURE 1

Power, Communication, and Achievement
From Monologue to Dialogue

"Hopeless" Poverty
Birth of "Unexpected"
 Child
Clinical Depression

may
lead
to

Parental
Powerlessness

Manifested
by

Increased
Controlling
Communication

Decreased
Mediation of
the World

Offspring
Powerlessness

Low Academic
Achievement

Increased
Power
Struggles

Low Motivation
for Requested
Achievement

Decreased
Autonomy

Altered
Toddler
Language

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be associated with economic status as much as with a psychological issue, the view of oneself in the world.

OPTIMAL DIALOGUE WITH PARENTS

"We See Only What We Know"

Goethe

"To Look at Phenomena so Long Until They Seem to Tell the Story by Themselves"

Charcot

Our longitudinal study adds corroborative evidence to the above. First we have evidence (Schlesinger, 1986) that parental dialogue strategies with deaf children also influence their academic achievement. Secondly, we note that as the "achievement" dichotomy of class belongingness disappeared, since the parents were middle class the dialogue features of mothers of successful and less successful youngsters sprang forth. Mothers of the more successful youngsters (from toddlerhood on) used strikingly different dialogue strategies than did the mothers of the less successful youngsters. The mothers (and the occasionally available fathers in our study) of the academically successful adolescents had been significantly more responsive to their offspring, repeated their toddlers more often and themselves less often, and asked more genuine questions of their children than did the mothers of the less success-ful adolescents (Schlesinger, 1982; Borchert, 1984).

These latter mothers appeared to join, and remain in, the perceptual world of their children. Through latency, they continue to label--through nouns-- the objects that their children see, touch, smell or "hear" in the world. Often their barren interchanges with their children, "What is this?", "An apple", at three, at five and at eight were difficult to bear.

The mothers of the more successful youngsters introduced a wider, more complex world to their toddlers. They too label the objects in the perceptual world of their childen, but add attributes to them via adjectives. In addi-tion, they label the actions and feelings of individuals in the world and characterize them via adverbs. Furthermore, they not only describe the world but help their children to reorganize their perceptual world and to reason about the world. They explain "you need to tilt the wagon." They ask: "What would happen if and when?" "What flavor is the color purple, usually?" "What department is cottage cheese in?" and "Is the ice cream delicious?" Their children answer these questions accurately and demonstrate if-then concepts, "If you didn't get a letter, I will go to Connie and get one for you." They use language for imaginative play episodes (playing Fish with empty building blocks), and ask questions about events in the world, "Why are the eggs stuck?" (Schlesinger, 1986). It was rewarding to note that as their children grew these mothers labeled less and reasoned more as did their children.

Parallels are drawn between the successful deaf adolescents and their hearing middle class peers and the less successful deaf adolescents and their

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lower class hearing peers and the dialogues with their parents as toddlers. Blank and colleagues describe middle class children who tend to reason about the world and lower class children who tend to label the world. "Lower class children become increasingly proficient in attending to and describing the world just before them; middle class children become increasingly proficient in using language as a tool to restructure and reason about their perception" (Blank, Rose, & Berlin, 1978, p. 75). In addition, the authors cite Tough (1977) who also found that working-class children use language to a much greater degree for "self-maintaining uses," such as expression of needs (I want . . .) or a protection of interests (go away . . . you are hurting me). Middle-class children are found to be more disposed to use language for "extending and promoting action" and for "securing collaboration with others" (Blank, Rose, & Berlin, 1976, p. 73).

As indicated previously, all the parents in our study were middle-class and their socioeconomic status was not the critical variable. Although the average hearing loss was a critical variable, it was insufficient to account for all the variations. The mothers of the successful youngsters were advantaged in other ways described above.

SUMMARY AND HOPE FOR FUTURE DIALOGUES LEADING TO ACADEMIC ACHIEVEMENT

There is hope for future dialogues between adolescents, middle and working class and their parents. There is hope for future dialogues between deaf adolescents and their parents. There is an environment that is inimical to optimal parent-child dialogue. No ethnic belongingness describes this environment, poverty per se does not produce this environment, nor does the parenting of disabled children, but crushing, hopeless, "casted" poverty (Ogbu, 1978), and any parenting associated with severe depression, or perplexity may do so. Rich or poor, parents of able bodied or disabled offspring, parents can function well. However, parents who have internalized pejoratives from others are less likely to provide an optimal communicative environment to their children.

In the absence of a responsive and mediated environment, youth misses out on the cultural transmission of information, values and attitudes on the part of the parental generation. According to Feuerstein (1977), these youth become culturally deprived individuals, not that they come from a deprived, or a depriving culture, but that they have not experienced the transmission of their parents' culture. There is evidence that groups with the highest levels of cultural identity manifest the highest levels of cognitive functioning (Stodolsky & Lesser, 1967). As Cummins (1986) has been quoted previously, "this is more likely when positive feelings for both cultures abound."

All is not lost when mediationally deprived individuals grow up, although they are described as showing rigidity, lack of flexibility, a lack of openness to the novel, and reduced modifiability. These dire findings are, however, remediable by environmental enrichment, an innovative program to be administered at adolescence or even later for hearing youth (Feuerstein, 1979; Feuerstein, Relmer-Jensen, 1980) and deaf youth (Martin, 1984).

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TWO PROFILES OF DEAF ADOLESCENTS:
SPECIAL SCHOOLS AND THE MAINSTREAM

ARTHUR N. SCHILDROTH

Since 1968, the Annual Survey of Hearing-Impaired Children and Youth has collected data on deaf and hard-of-hearing children in special education programs across the U.S. During the 1984-85 school year, the latest year for which there are complete data, the Annual Survey reported information on 50,731 hearing-impaired students. Of these, 26,175--oi slightly over 50%--were in the 12-20 year age range, the boundaries of "adolescence" as defined by this conference. The subject of this paper will be those profoundly and severely hearing-impaired adolescents--i.e., those having an average hearing threshold of 71 dB or greater in the better ear--within this larger group of 26,175 hearing-impaired students who were being educated during the 1984-85 school year either in a special school setting, residential or day, or in a mainstream setting. The two groups will be compared on various demographic, audiological, and educational characteristics.

Residential and day schools for deaf students have long been part of the special education scene and are fairly well-defined in terms of an educational placement. The mainstream setting, however, although also in existence for many years as an option for deaf children, exists in a chameleonic form and often assumes the educational coloration resulting from the philosophy or financial situation of a particular local school district. Some hearing-impaired students are called "mainstreamed" if they attend school in the same building as hearing students, even though they are not enrolled in any classes with these children. Some hearing-impaired students dip into the mainstream in the gym or the shop area; some are "mainstreamed" in the lunchroom, but not in the classroom. And there are those hearing-impaired children, often with less severe losses or a later onset of loss, who are integrated into academic

areas with their hearing peers: some only into math or less language-oriented courses, some also into English and other subject areas more dependent on language. There appear to be various "mainstreams" into which hearing-impaired children and youth can be steered by educators and others interested in their welfare.

During the 1984-85 school year two questions regarding type of educational placement were asked of the schools participating in the Annual Survey. One asked the "type of facility" providing the special educational service to the student. For this question, 8,989 deaf students aged 12 through 20 were reported to the survey as being in a residential or day school setting. For a separate group of 5,725 deaf students in the 12-20 year age range the schools reported them as being served in "special education classes within a facility for hearing students."

For the almost 9,000 students reported from a residential or day school setting, their placement appears to be fairly obvious: a separate facility with a separate faculty and staff trained to educate relatively large numbers of deaf--i.e., severely/profoundly hearing-impaired--students, (although some of these residential and day school students may receive a part of their instruction in an integrated classroom [Taylor, 1985]).

For the 5,725 students reported to the survey as enrolled in special classes within a school for hearing students, their classroom environment is not so clear. All of these students are reported to be receiving "special education classroom instruction," but many of them may also receive some of their instruction integrated with hearing students. In order to throw some light on this latter possibility, a second question regarding program type was asked in the survey: "Does this student receive regular classroom instruction with hearing students, either full or part-time?"

Almost 83% of the 5,725 severely/profoundly hearing-impaired students reported to be enrolled in special classes in schools for hearing students were also reported to be receiving some regular classroom instruction with hearing students. (Due to limitations of length imposed on the survey form, the amount of this classroom integration and the kinds of classes in which it occurred could not be ascertained). Because of this large overlap of deaf students receiving integrated classroom instruction with those who attend special classes in a regular school, the larger number of 5,725 students will be used in the following comparison of adolescents in a special school setting with those in an integrated or regular school setting.

A general summary of the demographic, audiological, and educational characteristics of these two groups appears in Table 1.

DEMOGRAPHIC CHARACTERISTICS

Age. Perhaps the most notable feature of the age distribution in these two settings is that regular schools have a higher percentage of children in the 12 to 14 year old age group than do the special schools, which, in turn, have a considerably higher proportion of older students, ages 18 through 20. This latter discrepancy is due almost entirely to the larger percentage of 19

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TABLE 1

Selected Characte.istics of Severely and Profoundly Hearing-Impaired Adolescents Ages 12 Through 20, In Special Schools (SS) and Mainstream Settings (MS)

	SS (N=8989)		MS (N=5725)	
1) AGE				
12-14 years	29%		38%	
15-17 years	36%		38%	
18-20 years	35%		23%	
2) SEX				
Males	57%		51%	
Females	43%		49%	
3) ETHNIC				
White	66%		66%	
Minority	34%		34%	
Black		21%		17%
Hispanic		10%		12%
Asian/Pacific		1%		3%
4) DEGREE OF HEARING LOSS				
Severe	24%		76%	
Profound	38%		62%	
5) AGE AT ONSET OF HEARING LOSS				
Under 3	87%		83%	
6) SPEECH AND/OR AUDITORY TRAINING	27% = No		13% = No	
7) STUDENTS USES SIGN	95%		76%	
8) ADDITIONAL HANDICAPS	32%		26%	
Uncorrected Visual		5.1%		3.4%
Emotional/Behavioral		7.4%		4.5%
Learning Disability		9.0%		7.4%
Two or More Additional Handicaps		9.9%		7.0%

Source: 1984-85 Annual Survey of Hearing-Impaired Children and Youth.

and 20 year old students in the special school setting, leading to the conclusion that special school students, for whatever reason, remain in these schools longer than do deaf students in regular schools. We shall return to this point in our discussion of multiply handicapped students in these two settings.

Twenty-three percent of the students in special schools reporting to the 1984-85 Annual Survey were born in 1964 or 1965, the years of the maternal rubella epidemic which resulted in such a large number of hearing-impaired children. Only 13.1% of the 5,725 deaf adolescents in regular schools were born in these two epidemic years. (Somewhat surprisingly in light of these birth year data, the percentage of students from the special schools reported with maternal rubella as a cause of their hearing loss [23.4%] was not very different from the percentage of rubella students reported from the mainstream [20.8%].)

Sex. Schildroth (1986) found a much higher proportion of males in 60 public residential schools than females: 130 males for every 100 females. The present study confirms this finding for the combined residential/day school setting, where 56.6% of the 12-20 year age group were males: 130.2 males for every 100 females. Deaf adolescents reported to the 1984-85 survey from the mainstream setting were much more evenly divided between males (50.9%) and females (49.1%): 103.8 males for every 100 females. This preponderance of males over females in the special schools has implications for school programming and staffing because males are reported to have significantly more learning disabilities and emotional/behavorial problems than females (Schildroth, 1986).

Ethnic Background. The two types of educational placement, special schools and regular schools, had similar compositions in regard to the general ethnic background of their students: 66% white and 34% minority. However, if specific minority backgrounds are considered, a slightly different picture emerges. Black adolescents were more heavily enrolled in the special schools (21.3%) than in regular schools (16.8%). Hispanic and Asian-Pacific students, on the other hand, were more likely to be enrolled in the regular school setting.

AUDIOLOGICAL CHARACTERISTICS

Degree of Hearing Loss. Only those adolescents with severe and profound hearing losses were selected for this study. (The criterion for a severe loss was an average hearing threshold between 71 dB and 90 dB across the 500 Hz, 1000 Hz, and 2000 Hz frequencies in the better ear and for the profound loss a threshold of 91 dB or greater in the better ear.) However, the students reported by the special schools had greater degrees of hearing loss than those reported from the regular schools: 76% of the students in specia' schools had profound losses, compared to 62% for the students in regular schools. Thus, the special schools appear to be serving a group of ·tudents more seriously hearing-impaired--as measured by unaided better-ear av·-rage--than--those in the regular schools.

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Age at Onset of Loss. A slightly higher percentage of deaf adolescents from the special schools in the survey had a prelingual hearing loss--i.e., before age 3--than did the students in the regular schools, 86.7% to 83.2%.

Recency of Audiological Exam. The students in special school settings tended to have more recent audiological examinations than those in regular schools. Sixty-one percent of the 8,989 deaf adolescents in residential or day schools for the 1984-85 Annual Survey had their hearing tested in 1983 or later; only 53% of the 5,725 regular schools adolescents for that school year had audiological examinations after 1982.

A surprisingly high percentage of students in both settings--over 94%--had sufficient audiological information reported at the three frequencies noted above to enable the survey office to calculate a better-ear average, although here again, a slightly higher percentage of special school students (98.3%) was reported with more complete audiogram information than that reported for the regular school students (94.0%).

Speech/Auditory Training. Deaf adolescents in regular schools were more likely to receive speech and/or auditory training on a routine basis than students in the special schools. Slightly over 86% of the integrated students were reported to be receiving such services, compared to 71% of the special school students.

Cause of Hearing Loss. The two school settings differed little in their enrollment according to causes of hearing loss among these students. As indicated earlier, students whose hearing loss was caused by maternal rubella were enrolled slightly more often in special schools than in the regular school setting, 23.4% to 20.8% Adolescents whose hearing loss resulted from hereditary factors were also more likely to be enrolled in the special school setting than in the mainstream: 12.9% of the special school enrollment in this study had hearing losses reported to be caused by genetic factors, compared to 11.1% in the regular schools. The only other cause group whose enrollment in the two settings was somewhat different is the students for whom an unspecified "other cause, before birth" was reported: 4.9% f r the special schools, 2.9% for the regular schools. A rather large percentage of these unspecified before birth causes is undoubtedly genetic in origin (Brown, 1986; Schildroth, 1986).

In general, the special schools tended to enroll adolescents whose causes of hearing loss are associated with greater degrees of loss than did the regular schools, a finding consistent with other parts of this paper.

One important qualification of the survey data regarding cause of hearing loss should be mentioned. For a large number of students the cause of loss as reported as "could not be determined" or "not available" or the question was left entirely blank: 34.4% for the special schools and 37.4% for the integrated setting. There was a rather large discrepancy between the two settings in regard to the category "Cause of Hearing Loss Not Available in Student's Record": 10.7% of the special school students, compared to 18.5% of the integrated students. In general, the records regarding cause of hearing loss appear to be somewhat better in the residential and day schools than in mainstream programs.

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OTHER EDUCATIONALLY RELEVANT CHARACTERISTICS

Communication. As might be expected, a very large majority (95.4%) of deaf adolescents in special school settings was reported to use sign language—compared to 75.9% of those in regular school settings. Similarly, programs for 91.7% of the special school students reported using sign language in their instruction, compared to 73.9% for the integrated school students. Data reported to the survey regarding use of sign language reveal that approximately 35% of each group had a family member using sign language in the home, although the quality of that language could not be ascertained. The data reported on sign usage in the home are very tenuous due to the large amount of "data not available"—almost 30%—for this variable from the residential/day schools, missing data which might increase the special schools' percentage.

Additional Handicaps. The deaf adolescent population in the special schools in the 1984-85 survey had a higher percentage of multiply handicapped individuals—i.e., students with "educationally significant" handicaps. In addition to hearing impairment—than did regular schools: 31.5% compared to 26.0%. This undoubtedly is one reason for the larger number of older students in the special schools, which, in turn, is related to the larger number of rubella-deafened students in the special schools: multiply handicapped students tend to remain longer in the secondary school system, and students with rubella reported as a cause of their hearing loss tend to have more additional handicaps than the non-rubella group (Trybus, Karchmer, Kerstetter, & Hicks, 1980).

The special schools reported higher percentages of multiply handicapped adolescents than the regular schools for each of the specific additional handicaps on the survey form: legal blindness, uncorrected visual problem, brain damage, epilepsy (convulsive disorder), orthopedic problem, cerebral palsy, heart disorder, mental retardation, emotional/behavorial problem, specific learning disability (perceptual-motor problem), and "other." However, for only three of the specific handicaps was the difference larger than 1%: uncorrected visual problem (5.1% in the special schools versus 3.4% in integrated settings), emotional/behavioral problem (7.4% versus 4.5%), and specific learning disability (9.0% versus 7.4%).

A further indication of the involvement of the special schools with multiply handicapped students is the higher percentage in these schools of students with two or more additional handicaps than in the regular schools— 9.9% compared to 7.0%.

SUMMARY

Using data reported to the 1984-85 Annual Survey of Hearing-Impaired Children and Youth, this paper has presented a comparison of 8,989 deaf adolescents enrolled in special schools for deaf students with a group of 5,725 deaf adolescents enrolled in regular schools. (Approximately 83% of the latter group was receiving at least some regular classroom instruction with hearing students). The comparison is not meant to imply a value judgment. It is intended simply to describe the deaf adolescents presently enrolled in

two different educational settings in order to alert counselors and others working with them to differences in the students enrolled in and emerging from two educational settings.

In general, the special schools' adolescent group was older, had proportionately more males and more black students, had more acute hearing losses--both in degree and at an earlier age--had more multiply handicapped students (especially visually impaired, learning disabled, those reported with emotional/behavioral problems, and those with two or more educationally significant additional handicaps), and enrolled more students using sign language than the students in an integrated setting. As noted earlier, Table 1 summarizes these differences.

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HOW WE CAN BETTER PREPARE OUR
DEAF CHILDREN AND YOUTH FOR
THE ADULT WORLD

ROBERTA THOMAS

This paper addresses the reasons why deaf adolescents
are not prepared for appropriate functioning in the adult
world and argues about how we can rectify that situation.
The fundamental argument is that parent counseling and edu-
cational programs that are based on accommodating rather
than annihilating deafness and that address our deaf chil-
dren as normal children who cannot hear will prepare them
for adult functioning. A special and unique peer interven-
tion program called Project HOPE is described as an example
of parent education where deafness is "depathologized" and
parents are enabled to look upon deaf children as normal
children who cannot hear. Changes in teacher training and
the content of deaf education are also proposed.

I am delighted and honored to be here with you today at this conference
about adolescence. I feel particularly lucky that this is Tuesday, and you
all haven't yet been "adolescented" to death! I promise to do my best to use
this advantage as profitably as I can.

I feel extremely well-qualified on the subject of adolescence. I have
survived the adolescence of two hearing children (they will have to speak for
themselves) and I have a 10-year old deaf adolescent who has been an ado-
lescent since the moment he started to communicate--testifying, I might add,
to the usually untold drawbacks of free and open communication.

My son told me the other night, after he refused to kiss me good night--I
should mention that my male children do not touch me between the ages of 8 and
19, suspicious that such contact might be at worst, a form of incest, and,
sexists that they are, at least unmanly--he told me that he wanted to be inde-
pendent; that we were both human beings; that _his_ body belonged to _him_ (this

had to do with the fight about the shower); that because I was his mother, this did not give me the right to tell him how to live. He added, coolly, "Life is a drama; each person chooses his own!"

Sometimes, he communicates on paper, especially after a conflict resolved in my favor. The notes are usually short, as in, "You are a child abuser!" My daughter, a lawyer, suggests I burn this one. Sometimes, they are more like full scale indictments, calculated to create as much guilt as possible, as in:

"To unknown Mom. You have hurt my Heart. From your unknown son.
Please try to find my real Mom and your real son." P.S. Grrrrrrr

This note added credence my long held view that most children and ado- lescents's astonishing ability to create guilt would make them exceptional Jewish Mothers!

I don't mean to suggest that adolescence is a laughing matter. I do find that laughing sometimes helps me keep sane and is probably a useful strategy for parents whose children's adolescence can be an undermining, debilitating, and terrifying experience for them and for their deaf children.

For parents of deaf children, adolescence can be a new occasion for the grieving they experienced when they discovered their children's deafness. The special fears they have for their children's future and their own sense of insecurity at parenting a deaf child can be overwhelming during adolescence. For deaf children--well-adjusted relatively content deaf children--adolescence brings them a special confrontation with their deafness, their place in the world, and a difficult, painful grieving process of their own to add to the usual and painful adolescent turmoil. For language rich deaf children, this is beginning younger and younger--too young for them to manage.

Deaf Schools and programs are also recognizing that their deaf students are less prepared and more vulnerable to the dramatic changes in their bodies and in the choices that confront all adolescents. This conference, addressing practical strategies and programs that can assist deaf adolescents is testi- mony to this new concern and new effort. The term "transition" has now become very popular and it is appropriate that all those concerned with preparing deaf children and adolescents for the future focus on "transition" and prepar- ation for the adult world.

I have to say that this recent emphasis on deaf adolescence and especially the rather universal use of the word "transition" makes me uneasy. When I first started coming across this term in the literature, I noticed that I had the same strange feeling in the pit of my stomach that comes upon me when I hear or read the term, "Deaf Norms." I have often suspected that "Deaf Norms" were created by the deaf education establishment to justify their system and make them feel better by the simple act of calling "normal"--as in "deaf norms"--the abysmal academic achievement and life preparation of our deaf children. By calling this underachievement "deaf norms," the blame can be put on "deafness" rather than on the systems that educate our children. "Deaf norms" are supposed to make everyone feel that deaf children who can't read

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are that way because of their deafness, a proposition certainly comforting to schools and frightened parents.

"Transition" as a term and category is beginning to have the same euphemistic purpose. "Transition" gives a respectable name and justification to the unpleasant reality that too many deaf adolescents are very much unprepared to cope with adult functioning.

I am not suggesting that there is a foul conspiracy afoot. I don't personally know a single professional, teacher or otherwise, who doesn't care about deaf children and who doesn't wish them the best possible education and preparation for the adult world. I just think that a large, massive system that educates our children hasn't been working very well and the language we use reflects, more accurately than we know, our own unconscious prejudices and preconceptions.

It is, of course, appropriate that this conference address strategies and programs that are essentially remedial in nature. But besides remediation, there should be another approach to the special problems of deaf adolescence. We might begin by asking ourselves why deaf adolescents are so ill prepared for adult functioning. We could look hard at this "crisis" for our children and ask ourselves whether the failure is a consequence of deafness or whether this failure is a consequence of the systems that control their education.

Deafness is certainly partly to blame. Deaf adolescence would be difficult even if every operational system was an absolute paradise. That is because it is difficult to be deaf and no program can change that. It is also always a struggle to find one's place in this world, to separate from dependency on family and this struggle is tremendously exascerbated by the inherent isolation and communication gaps created by the facts of deafness. Educational programs can't eliminate the stress and real life issues of deaf adolescence. The question for me is whether school programs are helping or whether indeed, they are in fact interfering with our children's growing up.

I would like to suggest that there are good reasons to believe that from the very earliest intervention programs through academic/vocational secondary and postsecondary programs, our children are not well served and not prepared to grow and prosper as self-respecting well-educated, well-employed deaf citizens. I think that a very very long time ago, we got off on the wrong foot, as it were, and though we have made some changes in how we educate deaf children--we allow them to sign their English, for example,--the changes are superficial. Despite the good intentions of educators and our government, we are not looking clearly at what our children really need or how to educate and serve them as deaf human beings.

I always think its useful to try and look at our children **as though we are looking for the first time.** What we see are children who are normal children who can't hear. The idea that "deaf" and "normal" are compatible is actually a radical idea because in a culture where deafness is stigmatized, that "normal" and "deaf" are compatible is an alien notion. For this reason, historically, the entire structure and overriding goal that has informed the education of the deaf has been to <u>annihilate</u> their deafness and make our

children somehow "normal." Because our model for "normal" is really "hearing," we have produced a system of education dedicated to making our children somehow "hearing." The term for this--right up there with "deaf norms" and "transition" is "overcome."

This process--this effort to make our children "normal" begins at the very moment of "diagnosis," a process that James Woodward calls the "pathologizing" of deafnes. Once again, our language betrays us. Our children are diagnosed as hearing impaired; they have a hearing loss. Think about the kind of attitudes reflected in the names of the places that diagnose and "treat" our deaf children; most frequently they are called Speech and Hearing Centers, and our children can't talk and they can't hear! Several Total Communication programs I have visited are called "Auditory Programs." Other little children go to schools; ours get therapy. Always, they are sent to a speech Pathologist. Until I had a deaf child, I thought pathologists cut up cadaver!

We parents are taught early to thin... not only that our children are not "normal," but that "normal" means speech and hearing. No wonder we rush to "oralism" that promises t' that we can make them "normal," that is, like hearing. No wonder that Sign Language was never looked at seriously as a language since its use would surely be "abnormal." No wonder that even in programs that call themselves Total Communication, the emphasis is on speech and on being like hearing people. The deaf kid who can pass as hearing is the great success story (the one, by the way, all parents always hear about from someone's Aunt who met someone on a streetcar in Toledo who knows a young deaf man who is a doctor and a lawyer and a Ph.D., who earns :10,000,000 a year, and who has perfect speech). All, because he had a wonderful Mother! This is what I call the Jewish Mother syndrome run amuck! I've never been able to understand why anyone thinks such a story will "encourage" any parent! I can't e en make my hearing children doctors, lawyers, and Ph.D.'s who earn $10,000,000 AND have perfect speech!).

Given the usual number of exceptions to absolutely anything, most deaf children who are orally educated are destined to become "abnormal." Without easy communication, children can't acquire the rich language base necessary for normal language development and all the other development that depends upon language development. Ironically, we make our children abnormal by the self-defeating process of trying to make them hearing. Not only do we retard our children educationally by this process, we commit the equally grievous crime of teaching them that a clearly indisputable part of what and who they are--their deafness--is unacceptable. Because the goal of "oralism" is to make our children normal--that is hearing--it fails, we fail, and our children fail.

Until recently, we must remember that deaf schools were as oral as every other existing deaf program. Though the students learned and shared a common language--American Sign Langauge--and shared a common culture, the administration and control was hearing and essentially reflected the view that speaking--being like hearing people, was the measurement of success. But "oralism" didn't work most of the time and so the deaf students were all doomed not only to being "unsuccessful" according to hearing standards, but also to feeling inadequate, incapable, like "failures." It seems like a

miracle to me that so many deaf persons survived this system and are whole, healthy, educated human beings!

The failure of "oralism" has had another, more subtle and equally damaging consequence. The oral system, by inevitably producing ".ailure," then took that failure as a demonstration of how deaf children "couldn't" achieve, couldn't be "normal," a viscious cycle if there ever was one, reinforcing the stigma of deafness in every generation. This is how "deaf norms" were created--to expla'n this terrible achievement--and how the entire system of educating deaf persons fortifies the view that deaf children are not, cannot be "normal" unless by some miracle (or a devoted Mother) could be made to be like hearing--i.e., speak and lipread English.

For a lot of reasons--all depressing--the advent of Total Communication has not substantially changed this. Especially where TC programs are located in hearing schools, the model for success is a hearing model. I don't think it is much different in deaf schools, most of which now call themselves, Total Communication.

In the "mainstream" programs that are at all decent and rational, deaf children are outnumbered and even where there are more than a tiny group in any given school, they are not encouraged to feel comfortable and good about being deaf. They can hardly help seeing their difference as deaf persons as a deficit and often feel as uncomfortable with their deaf peers as they do with their hearing peers. They have no opportunity to develop any positive sense of their identity as deaf human beings. The idea that their deafness should be "nurtured" would probably seem bizarre to most program administrators, though there are exceptions.

In the deaf schools, just as in the past, the children get a lot of sup-port by sharing a common language and a common culture and developing a sense of identity Among Their Deaf Peers. They also have the tremendous advantage of knowing deaf adults who do so much to nourish the children's sense of who they are. The very environment of the deaf school makes better language development possible because so much language is happening around them--that is, folks are signing, especially their friends and the deaf adults who are around. You will notice, however, that despite the great hoopla about Signed English, the deaf nor s have improved only mirimaliy. Part of this, is, in my view inherent in the limitations of Signed English, which is a limited version ʋf English and only really accessible to those who already know English, which excludes most deaf children. The other part lies in the weight of generations of low expectations, incoherent, unintegrated, unchallenging academic programs, and teacher training that is antiquated and still modeled on the oral philosophy.

Let's look at the whole business of low expectations and examine the impact on our children. If the schools do not expect and enforce high expec-tations from our children in every area of their deve'opment, the children learn to expect very little of themselves and ultimately to think very little of themselves. Low expectations encourage our children to accept a second class citizenship role. When a teacher doesn't expect children to do homework, to prepare an assignment, when an English composition that could be

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much better is given an A, our children are diminished! How can anyone have any self-respect if his/her fifth rate performance is applauded!

Even with some signing, the schools are programmed--inadvertently, of course,--to not really educate, and this failure, just as in the bad old days, is still blamed on deafness rather than on the system that educates our children. In other words, the message our children receive in deaf schools is not very different from the message they receive in many mainstream programs, the entrenched message of oralism - that deafness, non-oral signing deafness-- cannot lead to real achievement, cannot be "normal" the way being "like hearing" can. To be normal, deaf, and successful is just not part of either our vocabulary of our "ethos." We fail at educating our children to be both comfortable successful members of the deaf community and comfortable, success- ful participants in the hearing world.

Lest I have driven you into the depths of depression, let me assure you that I don't for one moment believe that we cannot do better. I know we can, if we have the facts and if we have the will. I'll even go so far as to tell you how! I'm not suggesting that I have all the answers, honest. I am saying that we do have very strong evidence of what doesn't work in educating deaf children. With a little tenacity and the view that deaf children are normal, we can dig out the subtle, entrenched attitudes and techniques that undermine our children's chances for success.

If we "depathologize" deafness for ourselves and see deafness as com- patible with "normal," our whole approach to educating our children is radi- cally changed. Instead of sustaining the system that tried to annihilate our children's deafness by making them hearing, we can create a system that accommodates their inability to hear and educates them to become members of both the deaf community and the hearing world. We need to remember the equality doesn't mean that all human beings must be the same; equality should mean that we respect the differences between human beings. It is on the foun- dation of just such respect that we can nourish and educate our deaf children.

If deafness isn't shameful and abnormal, then we liberate within ourselves the capacity to understand that speaking and lipreading isn't the only stan- dard for what constitutes "normal." We begin to see that our children need the opportunity to acquire language naturally, which they can do if it is visually accessed through their eyes in sign. Though learning English will and should also be a goal for our children, we can begin to understand that language and English are not synonomous, not to mention the fact that the English language doesn't exist inside a born deaf child waiting to be miracu- lously unleashed by a speech "pathologist." We can look at tne research - though God knows much more needs to be done--and see that the deaf children of deaf parents who are exposed to and interact in ASL from birth have normal language development and all the other development that depends on language development.

If there is one matter upon which every faction in deafness seems to agree--and honest, there is one--it is that all development and education depends on language development. They will even agree that there is a direct correlation between the age and intensity of input and the whole development

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of the child.   I believe that if deaf child en are allowed to be deaf and acquire their language naturally through their eyes, they will be capable of learning everything--the English language, information about their culture, the natural developmental stages of concept formation, and all academic and vocational subjects.   I also believe that this development and education can be substantially enhanced for the vast majority of deaf children with American Sign Language.   We must not forget that it is all deaf children we must be concerned with, not just those few capable of being the "exceptions" of whatever system.   Having just "dropped a bomb" as it were, I will try to explain what prompts me to suggest such an outrageous notion.

I remember one day picking my son up at school and watching him play in the playground with a large group of deaf kids.   They were all involved in lively dialogue in American Sign Language.   Put more than one deaf kid with another and this kind of communication usually takes place.   A deaf "Aide" in the school yard was chatting with them now and then.   Two really good hearing teachers, friends of mine, who signed English well, mentioned to me, laughingly, that they didn't understand a word the kids were "signing."   At that moment, <u>that the teachers didn't use the same language as the children seemed like a new startling revelation</u>.

The week before, I had read some research that documented, through videotaping in a variety of TC deaf classrooms in deaf schools, that the teachers and the children appeared to understand each other less than 50% of the time!   The deaf Aide, also a friend of mine, told me (after the hearing teachers had left) that the biggest part of her job was to run around the classroom explaining to the kids what the teacher had just "signed."

It came to me, in a sudden terrible epiphany, that there had to be something positively nuts about the fact that American Sign Language, the language our children used easily and fluently with each other, with no problems in comprehension, was simply ignored by the deaf education establishment, was never used to educate our children.   This suddenly seemed to me the ultimate in irrationality and a good example of the double standard that informed decisions about our children.   I remembered the "cute" story about the teacher who had to ask her deaf student for a "Sign" she didn't know, and suddenly saw it as a cautionary tale that demonstrated the tremendous linguistic impoverishment our children experienced, a condition none of us would dream of tolerating for our hearing children!   (Can you imagine your hearing child having a Yugoslavian teacher who had studied English for six months?   You'd be out on the streets with picket signs suggesting that the Principal be jailed for Child Abuse!).   I felt also--no surprise to my friends, I take these things so well--absolute pain that teachers, even those who did sign something--were not communicating with their students, and the resulting absence of achieving anything like good education was blamed on the children's deafness rather than the obvious, enormous gap in communication and subsequent language development!   Without sophisticated language, there isn't much point in discussing challenging Social Studies, English, and Science Programs; there isn't much point in addressing any of the other issues at all.

I'm not suggesting that there are no other educational issues, nor that ASL is the panacea of the future as "oralism," Cued Speech and Simultaneous

Communication were all tooted to be! I am suggesting that we open our minds
and spirits enough to tr' it! If we really believe that "deaf" and "normal"
are compatible, we need not fear using the language of the deaf community to
enrich and educate our children!

I can hear the objections! Well, it would be very hard. But think about
how hard "oralism" is, and that didn't stop us. We asked little babies w'*h
no language whatever to articulate words they never heard anc rarely
understood! We asked little children to lipread a language that is only 20%
visible on the lips, a language they didn't know. We asked deaf children to
be not deaf, and despite incredible failure (wh,ch we blamed on the children)
we persisted for one hundred years! I was a French teacher, and no one who
hired me thought teaching French/English was a good substitute for my being
fluent in French, absolutely fluent in speaking, understanding, reading,
writing! Parents may not have an easy time learning ASL--perhaps they never
will. That's O.K. A course or two won't hurt them, and they would take those
courses if they were available--they do in Philadelphia! Parents shou'd sign
any way they can, and that's fine! They don't need more guilt! But the
schools to whom we give our children for education, can provide a fluent
signing environment and education in ASL, with a meaningfully signed pidgin
when that seems appropriate! We must not forget the great untapped resource
of deaf people themsel es who could offer our children this fluent language.
So maybe they aren't "certified!" I take that as a point in their favor!
Certification represents a system that probably deflects creative thinking in
any education. A school that wanted to, could create and implement a role for
deaf adults.

Would the use of ASL really eradicate those deaf norms? Who knows! The
research is just starting. I just don't see why we don't try it, since
nothing else is really working if you don't use "deaf norms" ac a measure. I
also believe that the use of ASL in school programs would have the effect of
affirming our children's deafness, nurturing their spirit as deaf human beings
which is as important as preparing them for success in the hearing world.

I don't know ASL myself--a few expressions here and there, fortified by
Jesse's constant vigilance! Jesse has had, through his I.E.P., a deaf adult
in his classroom since he was two, and I know that his excellent English has
been learned through ASL as a second language. I sign "pidgin" wit him
myself, when he gives me a chance to sign anything! I took a few ASL courses
which really improved the way I signed and made me conscious and aware of the
fact that ASL is as complex, sophisticated and subtle as any standard
language. Jesse is a sophisticated person in ASL; he now has a lot he wants
to translate into English, which I do for him, whenever he asks. I sign with
him exactly as I now speak with you, and his English is becoming as sophisti-
cated as his ASL--from my observation, because he knows ASL.

His education, however, has not kept up with his language. The history of
deaf education is in the main responsible for this, a history that still
sustains incredibly inadequate teacher training programs, programs that
reflect the "pathologizing" of deafness and still have a hearing model for
success in deaf education. I know many dedicated, competent, teachers of the
deaf; they are wonderful despite their training, not because of it.

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Most teacher training programs include almost no training in how normal children grow, behave, and learn. I know of almost no courses in how human beings acquire language, an absolute necessity for teachers of the deaf. I am also stunned by how little English deaf teachers know, considering their commitment to English as a primary goal. There is little about the development of coherent, consistent, challenging academic programs, based, probably, on the view that language deprived deaf children couldn't handle such a program! Few teacher training programs include any deaf teachers, any input at all from deaf adults, any curriculum on deaf language and deaf culture. Deaf teachers and their certification reflect a view of deafness as a deficiency and do not prepare our teachers to educate normal deaf children. A friend of mine who runs a really good deaf high school program told me that interviewing new teachers is a depressing experience; their K through 12 certification simply doesn't prepare them to really teach high school subjects to high school deaf children.

I consider it a real priority that our children's academic education be a first rate education, as good as any education or achievement available to hearing children. But that doesn't mean trying to make deaf children hearing. Because we want deaf children to be well-educated, participate fully in the hearing world, have access to our civilization, all civilizations, and be well-employed does not mean to make them hearing! The point is that a good education for our normal deaf children will give them the opportunity to be participating deaf members of the larger community.

We must therefore also be sure that our deaf children's deafness is nourished so that they never feel that their deafness is something wrong with them. However successful our children are in the hearing world, I cannot imagine how they can possibly feel good about themselves if their deafness-- such a significant part of their being--is at best tolerated or ignored, at worst something they are supposed to "overcome."

As much as social studies, they need a positive reinforcement of their deafness, which comes also, in large part, through American Sign Language. By respecting through using (rather than through lip service) the language of the deaf community, we not only possibly access English and education, we also definitely access the deaf community, deaf people, deaf culture, and a good reason to feel good about being deaf! Surely our children, human children, deserve at least that much.

I'd like to make one last suggestion about improving the system that educates our children. I think that a very large part of what very subtly and unintentionally diminishes our children through the educational process is the fact that the whole establishment is managed by hearing people. If you were deaf, what message would you inevitably get if every major authority, every real power was hearing? How could you avoid internalizing the view that hearing knows and therefore is best? It is unavoidable to draw such a conclusion from the facts of their lives. The remedy is less easy. Deaf people are generally not well-educated precisely because of the system I have just tried to describe. They have really no models for first rate education. Deaf people also carry the burden of undoing, for themselves, the labels that were put upon them in their school years. Still, we created a system; why should

we lack confidence in any system deaf people worked out, who surely know better how it feels to be deaf? I always tell parents that every deaf adult they meet was once their child. Would they deny their children the opportunity to be a leader for other deaf children? Surely, we have an obligation to allow deaf people the right to at least share responsibility and control in educating deaf children.

I am not suggesting that we throw all hearing people out of deaf education and habilitation--that would also include me! I am suggesting that a change in the power structure would certainly benefit our children's self-image, their belief in themselves, and possibly also their educational achievement. I know for certain that however much I cherish and love my Jesse, he cannot look into my face and see his history or glimpse his future! Only deaf people can do that for him.

We had a project in Philadelphia called Project HOPE. Project HOPE was a peer intervention program that took advantage of the expertise of other par .s and our local deaf community for parent education and support. Visiting parents of very young deaf children in their homes, a team made up of one parent, one deaf adult, and one interpreter brought accurate information, support, and the reality of deafness to families in the Philadelphia area. Deaf adults did a fantastic job of helping parents understand their children's needs. The parent team member gave the kind of sympathetic support that only another parent can provide. This deaf/hearing team working together, modeling their experience, had a profound influence in Philadelphia. The project demonstrated that well counseled parents will let go of the fantasy of making their children hearing. Project HOPE also showed that deaf adults can have a positive, profound, and significant role in the habilitation of deaf children and the well-being o, their families. Project HOPE, I was told, was bound to fail. Schools would balk; parents would be terrified of meeting deaf people. It never happened. We can do more than we think if we have the vision and the will.

If I had my deepest wish come true--workshops give me the opportunity to act out my fantasies--the program I would choose for my son would have a first rate deaf environment with lots and lots of deaf kids to be pals with, to fight with, to whisper (in Sign) about in the locker room, to go to parties with (chaperoned!). This same program would have very high expectations, high standards, and an environment that created and sustained the motivation critical for achievement. His teachers would treat him with respect by expecting him to perform, to be responsible, to orchestrate his own life. These are "life skills" integrated into the fabric of his education, and not some separate course. If he got an "A," he would know that he deserved it by anyone's standard. An unearned "A" diminishes him; an earned "A" is an occasion for self-respect. There would be a lot of deaf folk around, to like, dislike, to be friends, enemies, to inspire him, to caution him. There would also be well-supported, interpreted, non-disruptive deaf-hearing interaction so he could learn to manage with hearing people as an equal. The most respected students in this program wouldn't be the ones most like hearing, but rather the students who were successful and responsible and deaf.

There is no such program for my Jesse or for any other deaf child. Jesse's present condition adds an ironic new twist to the struggle of deaf

adolescence. Language rich, he functions on grade level and beyond. Never "oral," he has never known the isolation and the absence of family communication created by oralism. Never outnumbered by hearing children, nurtured in a positive deaf school environment, he has never thought that his adequacy or success depended on how much he resembled hearing children. Now suddenly, his "deafness" has hit him like a truck. His "difference" has been an astonishing revelation to him. The world isn't his family or deaf friends; the world looks upon his "difference" as a "deficit." The deaf school that has been his comfortable home during the school day is boring him; the absence of a coherent, challenging program is diminishing him. Jesse's one mainstream class has made clear to him that his deaf shcool isn't educating him, but he doesn't want to leave it; he is, "conflicted."

Jesse also knows that his family can't "fix" this, can't "fix" everything any more. That is true, of course, for all children, but it is more shattering to a signing deaf child in a signing family (to any deaf child for that matter). Loved, signed with, successful Jesse is now in some ways the victim of his hard-fought and hard-won advantages! There is no place for this academically capable, bright, creative, bilingual deaf child that will give him both a full, positive deaf world and also educate him. Future options appear to exacerbate rather than alleviate his painful dilemma, a dilemma that is my personal grief for Jesse and for all deaf children—the bitter fruit of success.

I have presented you with some mighty radical views, I know. I don't suggest that I have the ultimate answer. But I do believe that we have the knowledge, the research, and the experience at this very moment to cast aside, energetically, what we know hasn't worked in the past. I also believe that we must have the courage to try new and better ways, ways that are available at this very moment to provide our children better communication, language, educational achievement, and a stronger, prouder sense of who they are.

All deaf children—now, perhaps more than ever—will inevitably have a more challenging adolescence than most hearing children because deafness is difficult and adolescence is their prime time for beginning to understand and experience their difference as deaf human beings. But I believe we can make it easier. If deaf children are brought up to believe that their deafness is not something shameful that must be overcome; if they are educated in an environment that provides them real role models for adult integration and success; if they have a lot of peers to interact easily with; if they are provided a first rate challenging academic education—if all these "ifs" were in fact reality, the adolescence and future prospects of deaf children need not be substantially more awesome than anyone else's. Deaf children can be educated so that they can take a proud place in the deaf community and the hearing world.

Certainly, some of what I proposed today is untested and untried and some would take moving mountains—like the teacher training programs—now that's a mountain! But other changes would not be so difficult. I believe we can provide deaf children the social and academic foundation they need. It will certainly take all our strength, our will, our vision, and our courage. But the goal is, after all, quite splendid—deaf human beings whose lives are not

"Impaired," but rather rich and whole and full. That is a goal worth working for and I am pleased and proud to join with you in that work.

TREATMENT OF THE
LARGER-THAN-FAMILY SYSTEM

MICHAEL A. HARVEY

Clinicians frequently report the phenomenon of fruitlessly expending much time, energy, and money toward helping some clients achieve their goals. These clients do not ever seem to make significant gains; others initially achieve notable gains only to suddenly regress. The clinician typically has a vague sense that this phenomenon had somehow been caused by outside influences which were not predicted. This, in fact, appears quite justified; for the usual mode! of providing services limits its scope to the individual. Many counselors do not explicitly acknowledge the critical importance of contextual variables--the environment in which the individual functions--although the importance of one's family is sometimes given passing mention.

The family therapy movement in the early 1950s expanded the perceived locus of a presenting problem from the individual to the family. It was demonstrated that any intervention with an individual is not limited to affecting only him/her, but rather affects and is affected by the context. The context was understood to be the interaction among all family members. Therefore, the family was viewed as the appropriate unit of therapeutic intervention.

However, it was an error to restrict the definition of context to the family. For as the family therapy movement became more sophisticated and succinct, an early misconception was corrected; namely, that family therapy meant to treat the family. This was fallacious. Family therapy is not one of several techniques to use; one does not "do" individual or "do" family therapy. Rather, family therapy refers to a new way of knowing and understanding human phenomena, a new "epistemology." One understands a presenting

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problem by examining it as a part of a web of other complexly intertwined human relationships which are not necessarily restricted to persons within the family. This "web" will hereafter be referred to as the ecological system.

The ecological system of a client who is deaf is often quantitatively and qualitatively different from that of a hearing client. One way of describing this difference is to simply list the people. There seems to be a one-to-one correspondence between the several ramifications of deafness and the number and kinds of persons who are involved in a deaf person's context. This web of intertwined human relationships--the ecological system--frequently includes medical personnel (i.e., an otolaryngologist, geneticist, opthalmologist, neurologist, cardio'ogist, etc.), mental health personnel (clinician, psychiatrist), school personnel (prinicipal, school counselor, teacher of the deaf, speech/language therapist, interpreter, notetaker), an audiologist, a case worker, an advocate, vocational rehabilitation counselor, parent consumer groups, deaf adults, deaf peers, etc.

It is significant that many of these persons also function within their own hierarchal bureaucracy (i.e., the state VR agency, Department of Mental Health, Department of Social Services, Department of Education, Medicaid system, S.S.I.) and thus are answerable to someone "higher up." For example, a school principal is frequently obliged to interact with a deaf student in accordance with the policies dictated by the respective Director of Special Education.

Thus the ecological system is both horizontal (may include several diverse persons) and vertical (each person is within a power hierarchy exerting a relative degree of influence over each other). However, the extent of horizontal and vertical expansiveness of an ecological system varies over time and according to the content issue being discussed with respect to the identified patient. For example, the Director of Special Education may exert more power over a decision concerning the funding of an academic placement of a deaf adolescent than would the VR counselor. However, the parents may rely more on the VR counselor's evaluation and authority for post-high school planning.

The ecological system of a deaf person is also qualitatively different than that of a hearing person. It is beset by several emotionally laden controversies regarding communication, cultural identity/membership issues, educational methodologies, etc. These controversies are well known to practitioners in the field of deafness and will not be elaborated here.

The movement toward an ecological perspective on deafness is not an isolated phenomenon. For example, Urie Bronfenbrenner's (1979) theories about The Ecology of Human Development have become increasingly important in the study and treatment of handicapped and disabled people of all kinds. His disciples, Jay Belsky and Carl Dunst, have demonstrated the importance of treating disabilities by focusing as much on the family and the interpersonal networks of disabled children as on the child per se.

Naturally, there are also problems in these pioneering ecological efforts. Environmental factors have been viewed as multiple, independent influences, and from a lineal perspective. Schlesinger and Meadow (1972), for example,

consider the influence of parents on the developing child. Levine (1956) explores the influence of cultural attitudes, again on the developing child. One asserts that child development--the dependent measure--is simultaneously influenced by several independent environmental factors. Although the reciprocity of influence between the child and environment is acknowledged, the emphasis remains unidirectional. It is as if the child is a tabula rasa, passively reacting to external forces.

It is important to view the environment of the developing child as an intricately woven fabric, with a form and an integrity different from any specific part. As the systemic axiom of nonsummativity maintains, "the whole is greater than the sum of its parts" (Von Bertalanffy, 1968). A woven design owes its form and integrity not to the individual colors of yarn, but to the relationship among the various combinations of colors, to the overall pattern. Consequently, to help a disabled child one should not only consider several important environmental factors, but also how these factors are related to each other. It is one thing to recognize that family and school influence a child. But it is equally important to note how the relationship between family and school influences the child, much as how the relationship between child and school influences the family, and so forth.

This ecological focus on the relationship among the various factors in the deaf child's environment is the subject of this paper. There are three sections. The first places deafness in a broader field by identifying some of the many levels of human systems which touch the development of a deaf person. In order to make the ecological perspective more vivid to the reader, the second section describes a single deaf person and her environment. The third section demonstrates how structural and cybernetic theory help to organize an ecological field.

THE MANY LEVELS OF DEAFNESS

There are many levels of organization in human experience, from subatomic particle or living cell, to complex organs and organ systems, to whole persons, to families, communities, cultures and larger societies. These systemic levels appear to be arranged hierarchically, with each level more complex than the one before and encompassing all those that come before it. Bronfenbrenner (1979) has depicted this hierarchy as "a set of nested structures, like a set of Russian dolls" which are inextricably linked with one another. Most research studies and clinical modalities address only one or perhaps two levels. This practice ignores what Minuchin (1974) refers to as a "holon"-- that any human system (individual or group) is simultaneouly a part and a whole. An individual is whole (complete), yet s/he is also a part of a family; a family is whole yet 's also a part of a community.

The effort to stop "chopping up the ecology" and to view experience from the perspective of many related levels of systems has been spreading from one field to another in recent years. For example, Urie Bronfenbrenner and his disciples have tried to apply this concept to the general field of child development and to programmatic efforts to help disabled, handicapped and chronically ill children. Israel Scheflen (1981) presented a similar view in his study of the Levels of Schizophrenia. George Engel (1977) has insisted

that the entire medical paradigm is Inadequate because it focuses so heavily on biochemical information to the neglect of psychological and social factors. His idea that diagnosis and treatment of illness must place illness in a broad "bio-psycho-social field" has been important to the recent development of Family Medicine and to the early efforts to establish a field of Family Systems Medicine.

The following is a brief discussion of those systemic levels which are most relevant to the study of deaf people.

(1) BIOLOGICAL. Obviously, biological factors are important. Here we include the etiology of deafness, the age of onset, the degree of hearing loss, the rate of hearing loss, prognosis for continued hearing loss or gain, the configuration of the audiogram across the speech range, and the amount of residual hearing. Furthermore, there may be related medical conditions and/or disabilities, depending on etiologic factors.

(2) PSYCHOLOGICAL. The particular characteristics of an individual person have a great influence on how he or she adapts to deafness and on how deafness is treated by his/her family, school and greater society. While deaf children may well pass through some common and identifiable stages cf development, each will do so in a unique way which is determined by his or her personality. This idea of personality can be further refined by discussing cognitive, behavioral and emotional elements. For example, a child who thinks that deafness is severely limiting will develop differently than a child who does not. An adult who considers him/herself deaf--as indicating a cultural affiliation, a source of pride and strength, membership in the deaf community--will obviously think, feel, and behave differently than one who considers him/herself--as simply disabled. Behavioral responses at each developmental stage, such as the degree of success at achieving independence, also become central to the psychological makeup of the deaf child.

(3) FAMILY. The family is the main environment for the developing child, particularly the young child. Its behavioral patterns, concepts about deafness, emotional responses to deafness, interactions with the deaf child, etc., all have powerful influences on the child. Furthermore, family development is powerfully influenced by the deaf child and by the demands of raising a deaf child in this society. In this sense, the deaf child influences everything, from the use of time and space to financial arrangements, travel patterns, patterns of communications among all family members, and to the family's image of itself--as well or not well, competent or incompetent, nurturant or not nurturant. The deaf child influences, and is influenced by, hearing siblings, grandparents, and extended family members.

(4) PROFESSIONAL. As with virtually all disabled or chronically ill people, many deaf clients have extensive and often intense relationships with a number of professional systems. These include

school and medical systems and other service agencies, like the state vocational rehabilitation commission, state department of mental health, etc.. These professional systems can be more or less relevant at different stages of the deaf person's life. For example, physicians tend to be important early on and remain important for a while, but school systems later become the most influential. The conflict among educators of the deaf concerning the appropriate mode of communication in the classroom--the "oral-manual debate"--is a well known example.

Professional systems and their relationships with family members become patterned over time and therefore exert an ongoing influence on the family. For example, parents often differ in their attitude toward plans for their deaf child, and a particular professional's advice can tip tne scales. Continued support for one parent's position can exacerbate the split between the parents. Alternately, continued support and guidance toward the child can undermine parental authority, as when a psychotherapist exclusively meets with the child --the identified patient. The undermining of parental authority also frequently emerges in the relationship among schools, parents and children, and schools and parents often compete about who is in charge.

The interpersonal patterns which emerge between parents and professionals may become so powerful that the boundary between the two systems virtually disappears. Therapeutic efforts to help the deaf child and his/her family are frequently impossible unless the ways that professional systems reinforce family patterns, and vice versa, are also addressed.

(5) INFORMAL NETWORKS. Informal networks made up of friends and extended family members can exert strong influences on family development and thereby on the development of the individual deaf child. The simple amount of support parents receive may determine how well they cope with the extra demands a deaf child may place on them. But networks may play more complex functions in much the same way that professionals do, i.e., supporting or opposing American Sign Language, "mainstreaming," or supporting one parent over another. Networks, like professionals, reinforce functional and dsyfunctional family patterns. Informal networks of deaf people play a major role in the development of deaf individuals. A typical situation, for example, may have non-signing parents, supported by a school system and their friends, finding themselves increasingly opposed by a teenage child who has finally found support for his emerging deaf identity from his signing deaf friends. This battle between parents and child may take on an even more intense quality than usual and resolution may be more difficult, because both sides' positions are "locked in" by their respective networks. On the other hand, the developmental task of adolescence--to individuate from the family-- may be made easier for the adolescent by the existence of strong peer networks. Similarly, parental networks may help parents through this rocky period. Thus, networks are important to consider, as they have many differnet influences on other systemic levels.

(6) CULTURAL AND POLITICAL. The way that a particular culture or subculture views deafness and, through its political process, the way that a culture provides for deaf children has a major influence on the development of each child. The efforts of the hearing culture to disband residential schools for the deaf, banish the use of American Sign Language, forbid deaf marriages, and even seek to sterilize deaf people, are some of the most poignant illustrations of the imagery of the predominant culture (Lane, 1984). Many deaf persons have incorporated an ethnocentric cultural dictum to act "normal"—which they define to be like hearing people—and thus spend much of their lives pretending to understand oral communications, frequently terrified that someone will discover their secret. The impact of culture on a deaf child's self-esteem is apparent. As Frank Bowe (1973), himself deaf, puts it, "The deaf child is typically bombarded with "can't, can't, can't." The result is the deaf adult who believes it. I was brought up with "can, can, can." It took me 20 years to believe it."

AN ILLUSTRATIVE CASE

In order to describe the multiple levels of systems which are inextricably involved in the lives of many deaf persons whom we see in treatment, and to ground ecological concepts in ordinary reality, we offer an illustrative case.

We begin with Susan, age 19 years. She has a congenital, severe to profound, bilateral, sensorineural hearing loss. The etiology of her deafness is maternal rubella. Susan also has a mild cardiac abnormality and "soft neurological dysfunction," both secondary to the rubella syndrome. In addition to an annual audiological check-up, Susan's mother brings her on occasional visits to cardiologists and neurologists for monitoring.

Susan is the oldest of three siblings of an intact family. Her speech is barely intelligible and, similar to most prelingually and profoundly deaf persons, speech reading is quite ineffective for her. Susan's primary and preferred mode of communication is American Sign Language. Since her family does not sign, Susan cannot understand most of the informal discussion in the household. Important discussions are equally difficult unless directed at her, and then she often understands only a small amount. When asked whether she understands, she either shrugs her shoulders or pretends to understand by nodding her head. Susan, however, does not need to pretend with her deaf friends; they easily communicate via ASL. She thus gravitates toward them.

Her mother, Ann, notices that Susan is "withdrawing too much," that she seems to be losing her fluency with speech and is not doing her homework. Ann believes that these changes are due to Susan's depression. "She can't accept her deafness." Ann tries to discuss this observation whith her husband, Bill, who is impatient with the idea of depression. He dismisses it critically and lectures Ann about being overprotective. According to Bill, Susan is "simply lazy" and Ann's concern is making the laziness worse. The arguement that ensues is so common as to be ritualistic in their marriage.

One of the ways that Ann tries to take care of herself is to belong to a support group for parents of deaf children, which, as usual, is composed

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almost entirely of women. Ann does feel supported by these women, and er view of Susan, Bill, and other aspects of raising a deaf child with an unsup- portive husband are validated. Bill finds himself spending more time at work and, on occasion, going out with some friends to a ball game. While he does not discuss the domestic situation in any detail, he does make cryptic references to Susan and to Ann's "coddling," which brings sympathetic nods from the others. In this way, Bill and Ann consolidate their positions and their feelings of martyrdom. They also consolidate their disengagement from each other.

Feeling abandoned by her husband, Ann also seeks consolation and support from her son, John, who is 4 years younger than Susan. Together, Ann and John approach Susan, half compassionately and half scoldingly, to say that she "should stop moping around." Susan feels infantilized by this strategy and believes that they are ganging up on her. As a result, she becomes sullen and more withdrawn.

At the same time, Susan's grades are in decline. Ann calls her school, which is a specialized day program for deaf children within a regular high school. Ann and the program director are already in an ongoing struggle, with Ann insisting that the school should mandate more speech therapy for Susan and the director finding Ann's concerns unreasonable. As a matter of fact, the director has tacitly agreed with Susan's teacher to "forget" to remind Susan to attend extra speech therapy. Susan complies because of her own sense of futility with speech. During several meetings with the program director, the teacher and a school counselor, Ann accuses them of being incompetent: "Why is Susan reading at a fourth grade level?" she asks. The director's response to Ann's accusations is to describe in detail how Susan is "acting out" in school. He recommends family therapy with a therapist who understands and uses Sign Language, thus trading accusation for accusation with Ann.

"Within the school system itself, the mainstream teacher, who does not understand about deafness nor about appropriate support services, repeatedly requests the interpreter/tutor to discipline Susan when she misbehaves in class. This, the tutor feels, is an inappropriate and demeaning request, and she covertly refuses to comply. Instead, she discuss with Susan "how it feels to be deaf in a hearing world." As Susan continues to disrupt the class, the interpreter/tutor complains to the director of the deaf program about the mainstream teacher. The director and mainstream teacher argue. As with Ann and the director, but in reverse, sides are drawn. With conflict raging around her, Susan continues to act out at school and at home.

As complicated as this situation already is, it goes further. Ann is upset and angry with the director of the deaf program and, instead of joining him in a team effort to discipline Susan, calls the director of special educa- tion in their city. She complains about the program and inquires about other programs. Furthermore, this time she is angry enough to call other parents. With trouble brewing, the director of special education calls the program director to suggest programmatic modifications and to "offer some constructive criticism of the curriculm and the faculty." The program director then yells at Susan directly, rather than through the teachers. Susan's behavior worsens.

Susan's problems are now undeniable, and Ann does initiate psychotherapy for her but with a clinican of her choice and with an individual format. The therapist neither signs nor has much experience with deafness. He meets with Susan with all good intentions, is careful to talk loudly and with exaggerated lip movements. This, of course, make speechreading more difficult. He disagnoses Susan as depressed and elaborates that "she has not yet come to terms with her deafness." He goes on the say that "she is impulsive, egocentric, and has difficulty introspecting since she is unable to understand abstract concepts," such as those he had tried to explain to her. Thus, he strongly recommends long-term individual psychotherapy, to begin prior to post-high school placement. This, he advices, "would improve her self-esteem as a deaf person. She is not yet ready to function in a hearing environment." In addition, he suggests psychotropic medication and a psychiatrist who will deal with that. The psychiatrist prescribes an anti-drepressant. Ann and Susan comply with the recommendations.

All of ise proceedings are upsetting to Bill, Susan's father. He views the therapisc's assessment as colluding with Ann against him. He is also much more concerned with Susan's ability to get a job in the future. "That's what we should focus on," he insists. "A job will make her independent." Accordingly, Bill contacts the vocational rehabilitation counselor for the deaf--"RCD"--with whom Susan has been meeting since she turned 17. The RCD had referred her to be evaluated at a specialized vocational evaluation center for deaf people. Based on their evaluation, the RCD advises that "Susan would benefit from vocational training in a deaf environment, with deaf peers and role models who use Sign Language . . . This placement should be away from her parents in order to encourage independence." Consistent with the traditional method of providing vocational rehabilitation services, the RCD had limited his contact and intervention primarily to the individual deaf client. Bill approves of the RCD's suggestions. Ann, however, sees them as colluding with her husband against her. The pitched battles continue, augmented with increasing numbers of experts, and placing Susan in the middle.

Susan's escalating depression and identity confusion, fueled by so many people speaking for her, soon alarm the individual therapist, who seeks the help of another therapist, fluent in Sign Language, experienced in working with deaf people, and capable of meeting with the whole family. In his referral, the individual therapist indicates that Susan has made no progress, partly because her parents provide little support. The family therapist complies with the referral and commences meetings. But the family therapist rapidly reaches a similar impasse. The family seems immovable and soon begins to miss appointments because of "car trouble" and other such rationalizations.

Both the VR counselor and the individual and family therapists had conceived the scope of the problem too narrowly. Each failed to place the problems in the broad ecological system which had developed around efforts to help Susan. As a result, each provider soon felt without adequate resources and, after trying interventions suited primarily to smaller treatment units, each encountered control struggles with the clients.

THEORETICAL NOTES

This scenario reminds us of a tangled up garden hose that somehow keeps twisting and turning and becoming more entangled. While it is apparent that the eco-system is important in the maintenance of Susan's presenting problem, it seems overwhelming to cogently "unravel the hose." it is clear that a model(s) is needed from which the clinician can understand the functioning of the eco-system and thus make effective interventions. Toward that end, we will briefly describe ideas of "nested structures," of Structural Family Therapy, and of cybernetics.

First, let us turn to the "nested structures" of the bio-psycho-social field. We noted that Susan was congenitally deaf as a result of rubella. Psychological testing describes Susan as depressed, concrete, and filled with denial about the long-term meaning of her disability. In her family, concern for Susan's deafness and multiple needs tends to "detour" or modulate the fighting between her parents. The parents grow apart and find support in groups outside the family: for the mother it is a formal support group; for the father it is his cronies. In addition, Susan's behavioral and cognitive difficulties at school exaggerate the structure of alliances in the family and exacerbate the conflict between her parents. Professionals are consistent and profound actors in the family drama and also serve to shape and reinforce family alliances. The professionals are frequently in conflict with each other—as exemplified by the members of the educational subsystem—or may be disengaged, as exemplified by the minimal interaction between the school personnel and clinicians. The unresolved cultural conflict about deaf people which is played out around the issues of Sign Language, deaf and hearing cultures, and mainstreaming versus residential schools, has an immediate and ongoing impact on Susan's psychological functioning and relationships with parents, teachers, and school administrators. And Susan's individual and interpersonal functioning, in turn, affects the cultural variables. Her behavior serves as further evidence to the culture that deaf persons are emotionally labile.

While it is interesting to see how generally intertwined these system levels are, it is important to try to be more specific about how the levels are related to one another. Without naming it, we have already begun to explore the value of Structural Family Therapy (Minuchin, 1974) in describing the ecology of deafness. Structural Family Therapy (SFT) focuses on patterns of behavior which reinforce dysfunctional activities, like Susan's "acting out" at school. To diagnose in SFT is to locate a "presenting problem" in the interpersonal field, and then to "restructure" that field to free the troubled person from having to produce the troubling behavior. If, for example, Susan's acting out seems to detour fighting between her parents—that is, if they focus on her rather than let their fighting get out of hand—and if Susan lends herself to this activity by getting into trouble, then a Structural therapist would try to help the parents to continue their own fight without Susan. If they could resolve their own conflicts, then Susan's "acting out" would cease to be functional, and she would free to behave differently. If the parents had alliances among extended family and professionals which interfered with the resolution of their fight, the Structural therapist would try to intervene in a broader field in order to release Susan from her "acting out."

From an SFT perspective, with its implict prescriptions for clinical intervention, there are a number of observations we can make about Susan and her family:

(1) Susan's problems appear to modulate conflict between her parents by keeping the focus on her. On the other hand, her problems may be said to keep the parents apart. Focusing on her stops her parents from dealing directly with, and perhaps resolving, issues of intimacy, antonomy, and power.

(2) Boundaries appear to be porous. Susan's problems intrude on the marital relationship. Susan's younger brother is encouraged to comment on her psychological state. Educational professionals are brought into the family to bolster various opinions and alliances.

(3) Coalitional structures seem to predominate. Within the family this may be seen in mother's alliance with John against Susan and in mother's alliance with Susan against father. Both father and mother enlist professionals against each other. At the same time, Ann joins or is enlisted by various professionals against other professionals, thus increasing rifts--for example, between "regular" and "special" educators.

A Structural Family Therapist delineates how Susan is triangulated into all of these shifting coalitions, conflicts, and alliances. Using the bio-psychosocial hierarchy as a guide, s/he also carefully maps the structural position of any additional subsystems not already mentioned: medical personnel, clinicians, informal networks, and cultural influences. After this diagnostic process is completed, the therapist tries to restructure the ecological system in order to release Susan from acting out. Coalitions may be blocked; for example, all one-to-one relationships would be encouraged. Hierarchies would be repaired. Parents and professionals would be encouraged to monitor their boundaries more closely.

Structural Family Therapy provides a well ordered and practical framework with which to organize the myriad of data that confront and often threaten to overwhelm the clinician. This is particularly important when clinical dilemmas revolve around handicapped or chronically ill people, whose symptoms attract a large, enduring ecosystem. However, the strength of SFT is also its limitation. It tends to create a static picture and to neglect change and development while emphasizing the present.

A cybernetic perspective is more concerned with the dynamic qualities of how systems co-evolve over time. What appears static from the SFT perspective appears dynamic from the cybernetic perspective. Specifically, cybernetic theory posits that living systems maintain their form through processes of change. Keeney (1983) illustrates this relationship by describing the tightrope walker who makes frequent adjustments in order to achieve balance on the high wire.

Co-evolution describes the constantly changing, reciprocal relationships which occur within and between systemic levels of the bio-psycho-social field,

the ecology. What happens at one level—how it evolves—is related to what happens at another level. For example, a change in the physical symptoms of a given child (at the biological level) would be related to a change in how the child feels (the psychological level), which is related to a change in how the parents relate to each other (the family level), which is related to a change in how the professionals relate (the professional level), etc.. All of these levels are said to co-evolve with each other.

Consider the ecology which includes Susan. We can list several examples of co-evolutionary relationships:

(1) The more intense the conflict among the educators (professional level), the more Susan impulsively acts out (psychological level).

(2) An increased level of conflict among the parents (family level) is related 'o increased polarization between the clinician, who supports hearing norms, and the VR counselor, who supports deaf norms (professional level).

(3) The more Susan's deaf peers support deaf pride (informal network level), the more Susan rebels at home (family level), and the more the deaf community is strengthened (cultural level).

(4) The hearing culture pathologizing deafness (cultural 'evel) is related to Ann's parent support group advocating oralism (informal network level); which is related to professionals advising Susan's parents against signing (professional level); is related to linguistic misunderstandings wi'hin the family (family level); which is related to increased egocentric and impulsive-like behavior by Susan (psychological level); which is related to Susan experiencing increased stress, physically manifested by increased release of adrenocorticotropic hormone (biological level).

The complexity of this case becomes obvious, but not because it is unusual. In fact, this case should be all too familiar to professionals in the field of deafness. It is complex only because symptomatic behavior is viewed in a broader context.

It is clear that a heuristic tool is needed which would represent the co-evolutionary relationships more concisely and in a manner useful to the clinican for diagnosis and treatment. Cybernetic theory uses the recursive cycle for this purpose. A recursive cycle is a dynamic, interactional sequence which exchanges and processes information, including imformation about a given person's symptom(s). The symptom(s) may indeed be embedded in the recursive cycle, which is repetitive, much like a homeostatic feedback loop. But cybernetic theory underscores the recursive cycle's capacity to change and evolve in response t internal and/or external forces. Recursive cycles help maintain the ba form of a system and, in fact, help reinforce symptomatic behavior. The clinician can "track" the discreet steps embedded in the cycle as ar. aid in understanding "the dance" of a system.

For example, we can arbitrarily begin with Ann and Bill arguing about Susan. As their argument reaches a specific level of intensity, Bill pulls in his friends and the rehabilitation counselor against Ann. Ann, n turn, pulls in her support group, special education director, and individual therapist against Bill. The professionals, having been triangulated into the conflict, begin to enact their own disagreements, turf issues, etc., and/or simply do not initiate contact with each other. Susan then acts out more. Her behavior confirms the cultural sterotype of deafness and, in particular, confirms her parents' views of her. They then attend to Susan, in an attempt to calm her down. After a period of relative quiescence, Bill and Ann again begin to argue about Susan. And this cycle repeats itself.

This recursive cycle contains six discrete steps which transmit and process information, i.e., Information about Susan. It is important to note that Susan's behavior and the resultant labelling and thus reification of her psychiatric symptoms by parents, professionals, culture, etc., is quite entrenched in this interplay of the ecological relationships. Although the steps and events in the cycle constantly change, frequently such changes are imperceptable, and thus the recursive cycle may appear circular—that is, unchanging.

The family therapist must interrupt this recursive cycle, using the plethora of intervention strategies which have been described in the family therapy literature. In order to effectively intervene in all levels of the bio-psychosocial hierarchy, the clinician must have a thorough knowledge about both systems theory and deafness. Further explanation on intervention is beyond the scope of this paper and will be described in subsequent papers.

CONCLUSION

In this paper I have described how the exchange of information which occurs with the ecology of deafness includes the reification of Susan's symptoms: namely, the assertion that her symptoms, and those of other deaf clients described in the professional literature, are manifestations of internal pathology. This is an extremely limited view. Rather, Susan's constellation of character traits may partly be seen as a relationship metaphor, a communication about relationships. The act of labelling symptoms is embedded in a complex set of dynamic relationships, both within and between levels of the bio-psycho-social field. Both the symptomatic behavior and the particular ecological field in which it is embedded develop or evolve together. They are essentially inseparable; one cannot exist without the other.

Therefore, it is fallacious to assume a priori that intervention should be directed toward the individual, or toward the family. It is not that simple. There are frequently non-family persons/agencies who strongly influence, and who are influenced by, the ecology including the deaf person. It is often the case that the presenting problem is actively maintained by a series of dysfunctional interactions among the "helpers" at all levels of the bio-psycho-social field.

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THE RUBELLA BABIES AS PARENTS

ILENE MINER

The Rubella babies of the epidemic of 1963-1965 are
becoming parents, facing the same problems of unemployment,
undereducation, and underemployment as their hearing ado-
lescent parent counterparts.

Among the 450 deaf patients served by Bellevue
Hospital (New York City) are 13 "Rubella mothers," 44 young
women of the same age who have not had children and 32
older mothers. The young mothers have largely left school,
cannot read, are dependent on social security and have no
plans for the future. Literature relevant to adolescent
parenthood is reviewed as are suggestions for program
development. Implicit in the findings is the need for
earlier access to health care services and counseling for
those who may see motherhood as an easy road to adulthood
or those who may wish to avoid pregnancy.

The Rubella babies of the epidemic of 1963-1965 are entering a new phase
of life presenting service providers with new challenges and difficulties
already known to the field of Adolescent Medicine: the Rubella babies are
becoming adolescent parents.

Bellevue Hospital Center is a 1200 bed, municipal hospital located in New
York City's borough of Manhattan. Patients served are primarily Hispanic and
reside in lower Manhattan. Services for deaf patients of all ages are
delivered through staff from the Pediatric Resource Center. The Pediatric
Resource Center has primary care physicians (especially for services such as
neurology, hematology, etc.), public health nurses, social workers, its own
psychiatric unit with both psychiatrists and social workers, a nutrition
program and child life specialists.

Because there are only three hospitals with services for deaf patients, two of which are voluntary hospitals serving only Medicaid patients or those who can afford to pay, Bellevue has a large number of deaf patients enrolled, close to 500 patients of all ages. Patients live in all five boroughs of New York City and several surrounding counties and some travel one and a half hours to their appointments. There are 35 to 50 patient visits a week; about 1/2 to 1/3 of these visits are for medical purposes; the rest are for family problems, school problems, concrete services, and related assistance.

Enrolled in the program are 45 deaf mothers--with children below the age of 13--who have a total of 74 children. Thirteen of the 45 mothers, who are between the ages of 19 and 22, have a total of 20 children. All but 3 of the 45 mothers are Black or Hispanic.

For purposes of clarity, "Rubella Babies as Parents" refers to deaf women, ages 19-22, born during the Rubella epidemic (i.e., during the years 1963-65) who have borne children before they would have finished secondary school at age 21. They are of course not all deaf from maternal Rubella, because for some it was not possible to obtain the etiology of their deafness.

ADOLESCENCE

Before examining issues related to adolescent parenting, it is important to look at adolescence, the period of time between puberty and the achievement of adult status. It is a dynamic process involving biologic growth, cognitive growth, and the psychosocial process itself. Some authors have found it convenient to divide adolescence into three periods: early, middle, and late. For instance, according to Hofmann,

> The rapidly developing physical changes in early adolescents focus their attention on their bodies; they become narcissistic. They test the limits of their independence but create no conflicts over control. In completing 95% of adult growth, mid adolescents have established a new body image; abstract thought begins to emerge, and they steep themselves in fantasy and idealism. The major struggle for emancipation develops, and the influence of the peer group attains major proportions. Late adolescents have emancipated themselves and established intellectual and sexual identities and for the first time face major decisions that have long lasting consequences (Hofmann, 1983, p. 7).

To successfully complete the transition from child to adult, an adolescent must have established himself as an independent person within the family, have developed his own value system and a secure and consistent sense of self, have an identity as an adult rather than a child, be capable of mutuality and reciprocity in relationships and be contemplating and planning for a functional place in society, i.e., work (see also Appendices 1, 2, & 3).

These tasks of adolescence are formidable and not always achievable. The transition from child to adult is often difficult and the process does not arbitrarily end at age 21. The period of adolescence may be more difficult and fraught with problems for the deaf teen who has the task of establishing his identity as a deaf adult who lives in a bicultural world.

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The deaf adolescent at age 21 is often just finishing his secondary education while his hearing counterpart has already spent three years in college or at work. He may well have grown up in a world that was sheltered but was without role models. As the deaf adolescent leaves the protection of school, his sense of trust may receive "innumerable jolts as he repeatedly meets others who do not accept his deficit, who appear fearful in joint human endeavor, who idolize a normalcy he cannot achieve instead of cultivating his unique areas of competency" (Schesinger & Meadow, 1972, p. 21).

This is often a time of tremendous family stress especially in families where the denial of deafness and its implications has remained intact for so long. "The generation gap may become an insurmountable chasm if the adolescent rejects the hearing world of his parents and if the parents reject the deaf world of the child" (Schesinger & Meadow, 1972, p. 23). This is the unfortunate situation in nearly all of the families of our patients. None of the parents can communicate comfortably with their adolescent or adult deaf children.

The effects of this denial of deafness are tragic.

Consequently parents and deaf children do not interact much. The deaf child is an isola.e in his own home . . . One effect of the denial of communication and accompanying stress is undereducation. Deaf children have the same IQ as hearing children, yet 35% are functionally illiterate when they leave school. Sixty percent test at fifth grade or below. Only 5% of deaf children when they leave school at 16 or older test at tenth grade or above. An obvious corollary of this undereducation is unemployment and underemployment (Vernon, 1976, p. 160).

The deaf patients who use Bellevue's services are largely Black and Hispanic. The issues of undereducation, unemployment, and underemployment are compounded for the minority deaf person. A full discussion of being Hispanic and Deaf or Black and Deaf is not within the scope of this paper. These issues have, however, been addressed in two books, Black and Deaf in America by Ernest Hairston and Linwood Smith and The Hispanic Deaf edited by Gilbert Delgado. Suffice it to say that discrimination and prejudice exist in our society-at-large, the results of which can be seen in educational performance and employment patterns among minority deaf persons. Responses to the learning needs of the Black and Hispanic deaf child remain inadequate.

The issues of undereducation, underemployment, and unemployment surface again when looking at the phenomenon of the adolescent parent.

ADOLESCENT PARENTHOOD

The difficulties of adolescent parenting are well-known. "In 1975, for example, 220,000 women age 17 and younger became mothers, many thereby ensuring for themselves bleak futures marked by truncated education, inadequate vocational training, economic dependency and poverty, large single parent families, and social isolation" (Phipps-Yonas, 1980, p. 403). All of these situations impact upon each other.

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Teenage mothers often do not finish high school. "Pregnancy Is the most common reason for girls failing to complete high school, with some 50-67% of the female dropouts being pregnant" (Phipps-Yonas, 1980, p. 403). Most of these girls do not return to school. Many of them were probably already at risk for leaving school prior to becoming pregnant and deciding to keep the baby. There Is Indication that patients who carry to term have had worse grades and more academic difficulties than patients who choose to abort (Olson, 1980, p. 435).

The Impact of this low educational achievement Is evident In two main areas: ability to parent well and future occupational opportunity. "Low levels of education may also be associated with a lack of knowledge of child development, leading some mothers to have unrealistic expectations of their children and low tolerance of children's behavior problems" (Kinard & Reinherz, 1984, p. 59). This sets up a situation which closely parallels characteristics seen In abusing and maltreating parents.

That young parents are Ignorant of child development issues and child care Issues Is extremely Important. The parent who has not yet completed her own developmental tasks, the parent who still needs nurturing will find It hard to adequately nurture her child. "Many of the teenagers studied had unrealistic expectations of a newborn, Imagining the baby to be like a doll or toy. Her wishes that Infant will fulfill her own needs may make It more difficult for the teenager to accept the newborn's Individuality" (Wise & Grossman, 1980, p. 445).

All parents go through adjustment upon assuming this role, but the teen parent, with her unrealistic expectations for the child, low educational achievement, general lack of knowledge about child care, and fewer options for future success, Is clearly at risk for a less than adequate adjustment. There is ". . . convincing evidence that a significant number of teenage mothers are emotionally and Intellectually Ill-prepared for their maternal role and fare poorly In that regard" (Phipps-Yonas, 1980, p. 416).

Leaving school early combined with motherhood leads frequently to a dependency on the welfare system. "Early childbearing Is also predictive of less prestigious jobs, which both pay poorly and provide little job satisfaction to the holder . . . This poor employment prognosis probably explains another common outcome for the teenage childbearer, dependency on welfare . . . While only 35% of the general population of women were mothers before the age of 20, this was true for 61% of women receiving welfare" (Phipps-Yonas, 1980, p. 414).

There Is, given the very real life problems faced by adolescent parents, reason to consider the risk of child abuse and maltreatment. Child abuse literature provides conflicting evidence. While some researchers found no evidence of association between parental age and child abuse, others report an unusually high proportion of teen mothers In abusing families (Kinard & Klerman, 1980, p. 482). Neither group has any record of success to build upon and both have a limited repertoire of coping mechanisms from which to handle stress.

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Both groups, abusers/maltreaters and the adolescent parents, have lives characterized by stress, isolation and poor educational achievement. They are often unemployed or underemployed because of lack of skills and have fewer options open to them. Knowledge of child care and child development is lacking and both often have unrealistic expectations of their children. "This finding of association between maternal age and the serious mistreatment of young children . . . demonstrates strikingly the very real and very negative outcomes that many children of adolescent mothers face. They are clearly a group at risk" (Phipps-Yonas, 1980, p. 429).

Clearly, adolescent parents require more service and intervention than older mothers who may already have experienced positive successes in their lives.

PARENT POPULATION

The population for the purpose of this paper is comprised of 132 women between the ages of 16 and 40 who were referred to the hospital for medical or social needs by agencies, schools, their friends or who were self-referred and who came to the hospital independently, i.e., without parent or caretaker.

This is an overwhelmingly minority population; 90.9% of the patients are Hispanic and Black (see Table 1). This is also true for women, ages 19-22, who are the Rubella epidemic generation; in this group only 3 out of 57 are not Hispanic or Black (see Table 2).

TABLE 1

Age and Ethnicity

AGE	HISPANIC	WHITE ORIENTAL	BLACK	TOTAL	TOTAL %
< 19	7	0	4	11	8.3
19-22	34	3	20	57	43.2
23-26	17	1	9	27	20.4
27-30	13	4	2	19	14
> 30	9	4	5	18	13.6
TOTAL	80	12	40	132	
TOTAL %	60.6	9.1	30.3		100%

TABLE 2

19 - 22 Year Old Patients
Motherhood Status and Ethnicity

	HISPANIC	WHITE/ ORIENTAL	BLACK	TOTAL
MOTHER	9	0	4	13
NOT MOTHER	26	3	15	44
TOTAL	35	3	19	57

Mean age at first birth was 18.5 for the Rubella epidemic age grou.) and 24.2 for the older mothers. Of course the mean age of the Rubella group will increase as time goes on and the population of mothers I..creases. Babies r^nge in age from a few months to 5 years of age ^ut most are between ages one and three.

Most of the 132 women are the only deaf member of their families; only 10 women have deaf parents, siblings, or children. Four women have deaf children. A!l of the Rubella epidemic age mothers are the only aeaf members of their famllle^ and have hearing children. None of the hearing families of these Rubella age mothers knows sign language; yet all of these mothers use sign as their primary mode of communication.

Although reports are optimistic about numbers of hearing parents of deaf children learning tu sign, this is not visible in our patient population. Communication problems at home aro often mentioned by all women still living with their families of origin.

LIVING ARRANGEMENTS

Young women who are pregnant believe that becoming a mother confers ins antaneous adult status upon them, never quite thinking through how early parenthood leads often to iurther dependency upon and need for help from their own mothers. Of our group of 13 mot^ rs, 9 continue to live with their own mothers. Two live in apartments with their husbands and children. One young mother, father and baby are homeless and are currently staying in a welfare hotel. The last lives with her husband but their child was removed by Welfare Court after he suffered a broken a. n at age 3 months and severe burns requiring several plastic surgery procedures at age 9 months (see Table 3). This one situation is one of the worst cases of abrse this author has seen.

This is the only reported case of child abuse or neglect in this group of 13 young mothers. In the older group of 32 mothers, there wer 3 reported c^ses of neglect, 2 in which mothers were abusing alcohol ana une in which urgent medical care for a child was not attended to. Those three situations were resolved and their cases with Child Protective Services werc closed.

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TABLE 3

Mothers and Their Living Arrangements

	AGE 19-22	AGE >22	TOTAL
Living with Family of Origin	9	6	15
Living Independently	4	26	30
TOTAL	13	32	45

SCHOOL AND TRAINING STATUS

Adolescent mothers tend to leave school and not return. In our group of 13 rubella epidemic age mothers, 11 are neither in school nor in training. Of the remaining two, one is working, and one returned to school (see Table 4). The one who returned to school is in a class for "slow learners."

TABLE 4

Patients Age 19-22
Education or Employment Status

	WORK OR SCHOOL	NOT IN ANY PROGRAM	UNKNOWN	TOTAL
19-22 year old Mothers	2	11	0	13
19-22 year old Non-Mothers	33	7	4	44
TOTAL	35	18	4	57

Of the 44 non-mothers in this 19-22 year group, 33 are in some type of educational, training or work situation including high school, continuing education, Vocational Rehabilitation placements for training or evaluation, or jobs. Seven are in no program and information was unavailable about four (see Table 4). It is clear that non-mothers are more frequently in school, training, or work situations.

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READING

An inability to read has a profound impact on every aspect of daily life. In a medical setting printed material is everywhere. Although testing reading levels was not feasible, it was possible to ask patients if they could read pamphlets around the office, directions written down by the doctor, or the newspaper. Patients also frequently bring mail in to be interpreted. Although the patients reading abilities are based primarily upon the author's clinical impressions and interactions, they are presumed to be fairly accurate assessments.

Of the 13 mothers ages 19-22, only 2 can read well enough to negotiate the medical system. Of the 44 non-mothers in this age group, 27 can read, 12 cannot, and information was not noted for 5. They read mc e frequently than the mothers (s Table 5). The reading levels of these Rubella-age mothers seems to indicate, as does the literature, that they may have already been doing poorly in school prior to becoming pregnant.

TABLE 5

Mothers and Non-mothers Ages 19-22
Reading Status

	READS	DOES NOT READ	UNKNOWN	TOTAL
Mothers 19-22	2	11	0	13
Non-Mothers 19-22	27	12	5	44
TOTAL	29	23	5	·7

Interestingly, of the 32 mothers ages 23 and older, 21 can read, 8 cannot read and information was not noted for 3 (see Table 6).

RELATIONSHIPS WITH FATHERS

Of the 13 Rubella age mothers, 6 have the father of the child involved on a regular basis. Two of the men work full time to support the family; both men are hearing. The husband in the couple whose child was removed by the court works intermittently. Four men living with the women independently or with extended family are not working at all. Six of the women have no contact with the fathers of their children.

In summary, 13 mothers who were born during the Rubella epidemic are receiving care at Bellevue. They are all Black or Hispanic and are from hearing families who know no sign language despite use of sign only by these

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TABLE 6

Mothers Reading Status by Age Group

	READS	DOESN'T READ	UNKNOWN	TOTAL
Mothers 19-22	2	11	0	13
Mothers > 22	21	8	3	32
TOTAL	23	19	3	45

young women. Eleven of the 13 are neither in school nor training. Only two can read comfortably enough to negotiate the needs of daily living. Eleven are dependent on SSI as are four of the fathers. The babies of the SSI-dependent mothers are also supported by public assistance.

THE PROGRAM

How do we deliver care to these young women who cannot read, are still dependent, and are involved with little beyond their still adolescent narcissim? Care involves much more than the narrowly defined doctor/patient relationship.

The Patients and the Setting

Health care is delivered to these young women and their children in the Family Care Clinic, where the Internal Medicine and Pediatrics units both have physicians. Most of the patients are hearing, and this program integrates services to both hearing and deaf patients. The goal is to deliver the same services to both hearing and deaf populations.

The delivery of medical and social work services to these Rubella age young mothers and their children has had to be tailored to their specific needs. Both mother and child often require and are entitled to services they are not receiving from systems they are ill-prepared to negotiate. These young mothers are often inexperienced in the care of babies; for some, this is their first experience in a medical setting using a sign language interpreter.

Understanding the need for medical care and involvement in that care is limited. As one young mother said, "No, I'm not going to bring the baby monthly; I'll just come when she's sick." Isolation within their own families has led to a lack of knowledge about their own and their families' medical histories. The mechanics of using the system seem overwhelming, where to get a clinic card, how to register, which person is a nurse and which person is a physician, etc.

There is a need for individualized provision of services, availability of information, and accessibility to the system at non-appo..tment times. The

provision of these along with the sign language usage by Clinic staff seem to account for the higher-than-average rate of kept appointments for all deaf patients (i.e., 80% compared to 62% for hearing patients). For the social worker this has meant the necessity of dealing with issues that are not strictly medical and a willingness to do advocacy outside the confines of the hospital. For the interpreter there is a need to explain about the medical system and a willingness to demonstrate how to negotiate it.

We have also built in a tracking system using a separate appointment book for deaf patients and giving them the responsibility of checking with us both when they arrive and leave so we will be aware of the next appointment. This facilitates our knowing who kept the appointment and who did not, who requires follow-up and recall and allows us to plan for hiring extra interpreters for exceptionally heavy days.

At the first meeting, because these young mothers have so many medical and non-medical needs, an in-depth interview is done. Developing a care plan includes a review of health history, educational, reading, and vocational rehabilitation status, relationships with family of origin and signing ability of that family, relationship with the father of the child, and his needs, living arrangements, income, need for day care, social security and public assistance benefits. Estimate is made of intelligence, goals, future plans, general mental health, and coping mechanisms especially for stress and anger. It is also important to note past history of psychiatric care and suicidal ideation and/or attempts.

THE IMPACT OF READING

The importance of knowing whether or not a patient can read cannot be overstated. These young mothers' lives are full of printed material both inside the hospital and out. Medical settings are full of pamphlets and instruction sheets such as information on contraception, sexually transmitted diseases, how to take a temperature, how to administer medications to a child or use medications, how to care for ear infections, operative sites, what to do for accidental ingestion of a toxic substance, consents for procedures, what to do when labor starts, and more. If the patient cannot read, and 11 of the 13 young mothers cannot, this information must be given in sign language. It is a time-consuming and sometimes tedious process; after information is given in sign language, the patient is asked to sign it back to check understanding or memorization if necessary.

Patients also frequently receive letters from Social Security, Welfare and other agencies which they have ignored because they cannot read them. All patients are told if they receive an offical-looking letter they cannot understand, they should immediately bring that letter to the hospital. The ten minutes spent reviewing the letter and making a plan is far less difficult than filing for a fair hearing for a closed welfare case or trying to get an emergency check issued for a hungry mother and child.

When needs are identified, referrals are made to the appropriate agency or service. For referral to outside agencies such as Welfare and Social Security, it is not enough to write the name and address of the agency and

Provide a list of required documentation. Appointments must be made and documentation explained in sign language. It becomes important to find out if the required documentation is available; many patients do not have their birth certificates, for example. This too is time-consuming but if an interview and acceptance for service are accomplished in one interview, it is time well spent.

Of the SSI recipient mothers, none knew they could apply for public assistance for their children; they simply did not know the program existed.

CHILD CARE AND CHILD DEVELOPMENT ISSUES

Knowledge about child care and child development is limited by an inability to read and also by the fact that interaction with possible role models is restricted. Because none of the families of these mothers sign, questions do not get asked or answered. In fact, issues of appropriate child care are often a point of conflict between these young mothers and their own mothers.

Child care and child development issues must be discussed at every contact to give information, to answer questions, and to reinforce good care. Many of the mothers do not know how to take a temperature, feed and burp a baby, how to dress a child appropriately. They also do not know the ages at which children roll over, sit, crawl, walk, explore. One crucial idea we have worked to communicate to these young mothers is our feeling that there are no stupid questions. If a mother has a concern, she is encouraged to use the health care system to get the answers.

LACK OF LANGUAGE DEVELOPMENT

We do have concerns about the language development of the children. In the children age 2 years and olde use of sign language is not being seen to the degree that it is seen in the children of older mothers. Communication is through the child's pointing, gesturing, pulling the mother toward a desired object or crying. One possible explanation, and it has been noticed when the young mothers are in the clinic, is that these young mothers are simply not communicating with or stimulating their babies enough. Babies have been noted sitting in strollers for long periods, rather passively, while the mother chats with her friends. A typical response from a young mother about communicating more with her two year old was "she's too young to talk or sign; I'll talk to her more when she's four."

For the purpose of language stimulation, we encourage referral to day care for these children. In fact, day care is routinely offered to all mothers who wish it. The Rubella age mothers have all rejected day care for their babies and toddlers.

Some of the mothers see their children's normal exploratory behavior as bothersome and "bad." Keeping watch over an active toddler can be exhausting and even boring but seeing this behavior as "bad" is an illustration of the unrealistic expectations some mothers have for their toddler-age children. This is similar to views of abusing mothers. Another young mother, when we

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were discussing accident prevention, said she had already made sure her 1 year old daughter would not touch cleaning supplies by _telling_ her not to touch. She really did not realize that this would not suffice because her daughter wouldn't understand.

This shows lack of knowledge and poor judgment. When judgment is poor, dangerous situations ensue. One young mother left her child in the stroller on one side of the subway station while she was chatting some fifty feet away with friends. This was witnessed by a staff member who can sign and who pushed the stroller over to the mother who was furious at what she saw as interference. Had the child been seen first by a police officer that child would have ended up in foster care. This type of situation is not uncommon.

Young mothers often complain about the difficulties of caring for a baby and state they had no idea it would be so hard. Two women who became pregnant shortly after giving birth chose to terminate the second pregnancies. Despite energy devoted to explaining contraceptive use, showing devices and pictures, making gynecological appointments which are kept, compliance with contraceptive use has been poor. It is here that adolescent thinking can be most clearly seen. The explanations as to why contraception is not used are "I won't get pregnant," "I only have sex once in a while," or "My boyfriend takes care of it." The last reason translates as withdrawal, not the use of condoms. These are, by the way, the same reasons that hearing adolescents give for not using contraception. This issue stills needs to be reviewed as frequently as possible.

LIVING ARRANGEMENTS AND FAMILY RELATIONSHIPS

Living situations are varied and relationships with families-of-origin are strained for some of these young mothers. Some of the grandmothers feel overwhelmed and angry by the continued dependency of their deaf child who is now a parent and resentful of demands for help. If our patient requests or allows, we set up a meeting with the mother's mother to better understand the home situation from the grandmother's point of view. Many grandmothers are responsive and feel relieved simply by having interest shown in their needs.

Some situations will not, however, improve. One young mother who developed gestational diabetes requiring insulin use resisted learning how to inject herself and was hospitalized in her eighth month of pregnancy until delivery. No family member appeared for a month despite calls and telegrams. Finally a home visit and statement about child protective services brought in a parent.

Another young woman, whose mother is primarily raising her child, moves back and forth between her mother, her father, and her boyfriend with no real place to call her own. That grandmother is overwhelmed and very angry that her daughter, who has not accepted responsibility for her own child, is expecting a second child.

The home situations of those who still are with their families of origin vary in that some young mothers are very much the mothers of their babies while others have virtually given up the role of mother. As one older mother

described her home situation, "this baby is for my mother; the next one will be for me." Some of the young mothers really do not want the responsibility of child care. Years of overprotectiveness and dependency have of course contributed to the idea to which some fervently hold, "I'm Deaf, I can't." Young women who believe this really will not attempt to change the home situation. If they are, however, willing to try, family meetings are held.

In other cases, struggles for control ensue, e.g., one young mother and baby spent time living with her boyfriend and his mother. The young mother constantly complained that her boyfriend's mother was assuming the parental role. A family meeting was held in which the boyfriend's mother bitterly complained about how frequently the baby's mother suddenly left for days on end without warning. This young mother just assumed the baby would be cared for and when she was lonely, just left to visit her own family and friends. Several meetings were required to clarify issues and subsequently the home situation improved dramatically.

SOCIAL RELATIONSHIPS

Some young mothers are extremely isolated from other women and men their own age and really socialize only at the hospital. Some live in the more inaccessible areas of the city or have limited travel skills. One example is a young mother who knows how to travel to the hospital but did not know how to travel to a social service agency one subway stop from her home. Two young mothers have wide circles of friends. Eight of the young mothers are home all day, every day with their children and are overly dependent upon them to keep themselves occupied. They have refused day care services. It is doubtful they will ever return to educational or rehabilitation service settings.

A goal we have is to set up a young mother's program using the model of our own program for mothers below age 18. The program includes medical services, infant stimulation, and child development education. Group meetings are scheduled for a weekly 3-hour session. Currently we do not have the staff to set up such a program.

EMPLOYMENT AND EDUCATION

There was an unexpected finding in these case reviews that is significant. Women who are mothers are overwhelmingly not working and are not in school or training. Of the 32 mothers older than 22 years of age, only one is currently working. Two others had significant work histories but developed second medical problems (see Table 7). It may well be that an important part of the educational and rehabilitation service programs should be to assure access to medical services for deaf adolescent women who wish to prevent pregnancy.

SUMMARY

In summary, the very special needs of this unique group of mothers requires special programs and services to meet their needs. They live in family situations where they cannot get information. They know little about child care and child development. A lack of ability to read results in an inability to negotiate not only the medical systems, but other systems that

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TABLE 7

School Program or Work Status
of Mothers and Non-mothers

	WORK OR SCHOOL	NO WORK NO SCHOOL	UNKNOWN	TOTAL
Mothers 19-22	2	11	0	13
Mothers > 22	1	30	1	32
Non-Mothers <19	11	0	0	11
Non-Mothers 19-22	33	7	4	44
Non-Mot' 'rs > 22	24	7	1	32
TOTAL	71	55	6	132

Impact on their lives as well, such as welfare and social security. These difficulties must be anticipated and provided for with enccuragement, information and advocacy. It cannot be assumed that their own families-of-orgin are willing and able to perform these tasks. It is and has been an ongoing goal to demonstrate to these patients that in fact they can care for themselves and their children and assume the responsibilities inherent in these tasks.

The characteristics of undereducation, underemployment, and unemployment that are so troublesome as aspects of deaf adolescents' and adolescent parents' lives are clearly evident in this small sample of deaf adolescent parents. They are at risk for child abuse, continued ec 'nomic dependency, and a rather dim future. They have responsibility for a new life when they have not yet completed their own developmental tasks. Their lack of ability to negotiate existing service delivery systems is apparent and has implications for program planning and service delivery. These young women will probably not return to educational or rehabilitation services and will continue to require far more support services than their non-mother counterparts.

A variety of support services is necessary. An outlet for the frustration that can often lead to child abuse is crucial, as is support for reaching for the wider world of deaf adults as a way of reducing isolation and having contact with appropriate role models. Young deaf teenage women need to see early that there is a productive, rewarding life beyond early motherhood. More interaction with deaf teachers, deaf social workers, deaf rehabilitation counselors and deaf adults in the community starting at a very young age is one way of possibly meeting this need. There needs to be a nurturing of positive self-identity as a deaf child, teen, and adult. There also needs to be a reward for postponing early childbearing in the form of work and a place in society.

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There is no easy answer or solution to the problems of adolescent parenthood. If there were, we would not now be faced with the epidemic of teenage pregnancy that exists. Because the effects of early parenthood are so pervasive, and the outlook so dismal, we must continue to try. I am reminded of a fund-raising slogan for predominantly Black colleges used some years ago, "A mind is a terrible thing to waste."

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APPENDIX 1

Characteristics of Ear.y Adolescence

1. Beginning of secondary sexual characteristics

2. Concrete thought still dominates

3. Cannot perceive long-range implications of current acts

4. Preoccupation with body changes

5. Compares self with same sex peers

6. First exploration of world outside the nome

7. Peers gain in importance

8. No major struggles with parents over control

9. Ages 11-13 to 14-15

Adapted from Hofmann, A. (1983). <u>Adolescent medicine</u>. Menlo Park, CA:
Addison-Wesley

APPENDIX 2

Characteristics of Mid Adolescence

1. Secondary sexual characteristics well advanced

2. Growth about 95% complete

3. Appearance of abstract thought

4. Can begin to see future consequences of current acts

5. Preoccuption with fantasy and idealism

6. Conflicts with family over control

7. Beginning struggle for emancipation

8. Strong need for identification with peer group

9. Looks to peer group to define behaviors and values

10. Testing ability to attract members of opposite sex

11. Preoccupation with romantic fantasy

12. Ages 14-15 to 17-18

13. Narcissistic in relationships

Adapted from Hofmann, A. (1983). Adolescent medicine. Menlo Park, CA: Addison-Wesley.

APPENDIX 3

Characteristics of Late Adolescence

1. Growth: physically mature

2. Abstract thought is present (if it is going to be at all)

3. Capable of orientation to the future

4. Functional identity established

5. Emancipation complete

6. In family more adult-adult relationship rather than child-parent

7. Individual strong relationships over peer group

8. Can form relationships with mutuality and reciprocity rather than narcissism

9. May be thinking of marriage and family

10. Capable of real intimacy and commitment

11. Age 17-21, upper end variable

12. Own value system has been established

Adapted from Hofmann, A. (1983). Adolescent medicine. Menlo Park, CA: Addison-Wesley.

EXPLORE YOUR FUTURE: AN NTID
PARENT TRANSITION WORKSHOP

JUDY EGELSTON-DODD
ELIZABETH O'BRIEN
JEAN BONDI-WOLCOTT

There is currently a major focus on the transition of hand-
icapped youth from school to work. We need to assure that stu-
dents who have been educated under P.L. 94-142 will find their
place in adult society.

The strength of the market for technical skills predicates
the need for a program of basic technological literacy and of
motivation to direct handicapped students toward training for
future employment in various technical fields. The successes
achieved by the National Technical Institute for the Deaf (NTID)
at Rochester Institute of Technology (RIT) in training hearing-
impaired students for employment in a variety of technical
fields have been well documented (Veatch, 1985). NTID's primary
mission is to prepare young deaf adults for employment. The
Institute has a multidimensional approach to ease the school-to-
work transition, weaving work concepts throughout the student's
learning experiences. The strategies include Co-op and other
work experiences, simulated work environments, infusion of work
concepts into coursework, and a formal course on the "World of
Work."

The continuing concerns expressed by NTID instructors and counselors
regarding the lack of knowledge about the various fields of technology,
appropriate work attitudes, and decision making skills, led the thrust to
approach the secondary audience with a systematic program of career outreach
activities. The transition addressed for high school deaf students consists
of a move from secondary school to the next appropriate life choice, be it
work or training at the postsecondary level (Egelston-Dodd, 1987).

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Leaving a school environment, either mainstream or residential, can be a stressful experience. It can be especially traumatic for deaf adolescents who may have developmental and experiential deficits resulting from their deafness.

To make hearing-impaired students and their parents aware of the combination of skills and attitudes needed to succeed in the study of math, science, and technology, a career education program was designed and entitled "Explore Your Future." Activities enable students to evaluate their own personal preferences and abilities, provide opportunities to use decision-making and leadership skills, to cooperate with others, and to understand their values and needs in light of career exploration concepts and technical competence for a successful career. The one-week program is designed for secondary, hearing-impaired students between their junior and senior years of high school, to be held on the NTID campus. The goals for "Explore Your Future" include the following:

1. Increase awareness of self using vocational assessment and career exploration activities.

2. Increase knowledge of academic skills and occupational requirements.

3. Increase motivation to pursue the improvement of basic skills where needed.

4. Experience a taste of college life at NTID at RIT.

5. Develop a plan for their last year in high school and any appropriate postsecondary plans.

Faculty members from NTID's Schools of Business, Science and Engineering, and Visual Communications, along with career development counselors and NTID career opportunities advisors, present classes and guide students through individual and group learning activities. These activities are designed to foster decision-making and an awareness of the basic skills needed for technical careers. Students participate in strategies involving risk taking, teamwork, and communication challenges with people in a variety of settings.

Each student attending "Explore Your Future" is offered hands-on learning experiences revolving around outdoor education, field trips, and career exploration labs, all designed to help students develop a greater sense of self-awareness and to develop awareness of a variety of technical career skills.

TAKING A PEEK AT COLLEGE LIFE

The activities of "Explore Your Future" promote self-awareness through vocational assessment and career exploration activities. The challenges of outdoor experiential activities enhance students' awareness of teamwork, risk taking and achievement. The Holland Self-Directed Search and Differential Aptitude Test are used for vocational assessment and feedback for positive

self-concept development. In Individual and group sessions with NTID coun-
selors, students analyze their experiences for relevant Insights and self-
awareness.

The strategies used also promote knowledge of academic skills and job
requirements for technical careers. Exploration activities focus on the
skills and tools used In computer science, engineering, business, visual com-
munications and science careers. Motivation for studying math and other basic
skills Is Infused Into every module. A collection of 15 career videotapes
focusing on each of the technical majors offered at NTID Is a viewing option
available to students who wish to observe the work site. A tour of several
local Industries provides a first-hand observation and chance to Interview
deaf people about their jobs and lifestyles. Role models are used as a
resource for career development.

The activities of "Explore Your Future" also promote an understanding of
college life: getting along with others, studying, managing time, attending
classes, and separation from home. There are structured floor meetings to
establish a policy of self-governance among students and mentors. Captioned
films and supervised athletic competition provide a taste of the recreational
opportunities on campus.

The program provides structured activities that enable students to eval-
uate their own personal preferences, abilities, and opportunities to use deci-
sion-making and leadership skills, to cooperate with others, and to understand
their values and needs In light of career exploration concepts and technical
competence needed for a successful career. As a result of their participation.
In the program, the students will:

○ Identify a technical change In their life that shows the evolution
   of technology and how this may necessitate career change.

○ Evaluate how choice of career Impacts on life style (level of edu-
   cation Influences level of employment).

○ Identify the steps In career growth, evaluating the level of educa-
   tion and the level of employment.

○ Choose to collect Information to make a preliminary career deci-
   sion.

○ Recognize the need to continue developing educational plans.
   (Emphasize the need for continued plans during their senior year of
   high school.)

○ Experience an Introduction to five technical disciplines and view
   how all technologies relate to and support each other in business
   and Industry.

○ Recognize the need to respect and accept a variety of communication
   modes.

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° View role models as a resource for their career development (NTID students or graduates).

° Evaluate the impact of various internal factors on their decisions, e.g., values, interest, abilities, goals. Recognize that these factors can change.

° Evaluate the impact of various external factors on their decisions, e.g., parents, teachers, stereotypes.

All students applying for "Explore Your Future" must have:

° a severe to profound hearing loss and need for educational support.

° an educational background that shows a probability for success in a technical postsecondary program, including a strong aptitude for math and science.

° references that indicate personal and social maturity.

° successful completion of their junior year of high school and an interest in technological education.

The Explore Your Future FY' 86 program offered this year is the result of much refinement and incorporation of recommendations made through evaluation of last year's pilot program.

The technical exploration goal was established to provide an introduction to technical disciplines of visual communications, business, computer science, engineering and science in a generic sense and to describe how all technologies relate to and support each other in business and industry.

The technical exploration components consist of a 90-minute lecture/hands-on technical experience as well as a 30-minute follow-up technical counseling session for each of the five technical disciplines. The follow-up component allows for the analysis of the data, people, and things functions in each of the technical areas.

To complement this intense technical presentation, individual counseling sessions and group presentations related to work values and decision making will be given. The decision-making process will be fused with the career technical exploration through the presentation of the concept that al' technology is interrelated in the world of business and industry and will affect each individual in different ways. This concept will be graphically presented to students through the use of the "cube of knowlede," with one side representing each technology. The sixth side of t'⋅e cube reflects the individual (a mirrored mylar surface).

PARENT TRANSITION WORKSHOP: AN INTEGRAL PART OF THE "EXPLORE YOUR FUTURE" PROGRAM

Capping the week's activities is the NTID Parent Transition Workshop. A review of the literature indicates that the career education movement has

always acknowledged the importance of the family influence on a child's career development through its inclusion of the home and family component. However, limited research and development has been done with this important aspect of career education (Laramore, 1980). Navin and Sears (1980) investigated parental involvement in career education/career guidance at the elementary level nationwide, and found it to be minimal. Hoyt (1981) indicated that some attempts were initiated to involve parents in career education's first decade, but these attempts were rarely effective. Various career education programs designed to address the needs of handicapped children cite minimal parent participation and interest after students reach the secondary level.

The home is one of the most influential factors on the attitudes of youngsters toward work, school and the larger society (Cathie, 1979). Rich (1985) maintains that historically parent programs centered on early childhood, neglecting the reality that children need ongoing support as they move through school. Reviews by Bronfenbrenner (1970) and by Ryan (1974) attest to the positive roles that parents can play by assertively involving themselves in their children's educational program. Walberg's study (1984) found that cooperative school/parent partnership programs that focus on improving academic standards by involving the home show the greatest learning effects.

While there exist some comprehensive documents/studies on career education needs/programs to meet the needs of the handicapped (Brolin, 1978; Peterson, 1979), various career education programs call for minimal parent participation. However, Vasa (1979, 1980) views the challenge for educators to initiate and maintain parent involvement in career education for their handicapped child. Parents need to understand that career education is a curricular approach to education that focuses on the educational and developmental needs of the handicapped child (Lewis, LeFevre, DiPalma-Meye, & Rimal, 1981).

Meisegeir's study (1982) examined parent's influence on occupational goals for deaf students and found good communication between parent and child to have significant impact on the child's career development. Mendelsohn and Fairchild (1985) report that parents of "older deaf children" are in critical need of help from professionals on how to provide skills to enable the deaf adolescent make a successful transition to adulthood. Several studies supported the conclusion reached by Hansen and Caulfield (1969) that there is a desperate need for parents to have some career information so they are aware of the variety of occupational fields and the rapid changes in these fields which will mean less stability in their child's career development.

Educators of the deaf in residential and mainstream programs were surveyed regarding the importance and urgency of a list of career education topics for parents of deaf students. Parents and educators were in agreement on 16 out of 22 comparisons. These topics were researched, and the content of the National Project on Career Education (NPCE) Parent Career Education Workshop was designed based on the highly urgent and most important concepts revealed in the survey (O'Brien, LeNard, & Egelston-Dodd, 1983).

The NTID Parent Transition Workshop has been developed to facilitate parents' "letting go" during the transition time when school is completed and before the next life stage is entered.

The goal of the NTID Parent Transition Workshop is to facilitate parents' involvement in the changes which their deaf adolescent will encounter upon leaving school. The workshop consists of two modules which occur the last day of the "Explore Your Future" program. The following is a description of the objectives and strategies for each module.

One objective of module one is that parents will become aware of the need to encourage independence in their deaf adolescent. The second objective is that parents will identify ways they can assist deaf adolescents with responsible decision-making. Trainers initiate parent participation through a ten-question strategy (Attachment A). This activity requires parents to discuss their own adolescent experience in letting go of the depending relationship with their parents. This strategy provides the parents an opportunity to interact and share experiences in a small group setting. At the conclusion of this activity, parents return to the large group for a series of processing questions, e.g., "What have you done to assist your deaf son/daughter with their independence?" "Can you give us some examples?"

Objectives of module two are: 1) Parents will acknowledge the need to "let go" of the parent-child relationship so that it can develop into an adult-to-adult relationship; 2) Parents will identify strategies to prepare their deaf adolescent for college.

A panel of three parents who have or had a deaf son or daughter in a post-secondary program, respond to a series of questions that focus on their experiences related to the transition from high school to college. A sample question: "Can you share something that you did with your deaf adolescent that made the process easier and transition smoother?"

A question and answer period between the audience and the panel follows the presentation. Processing questions are given by the trainer which focus on key concerns and strategies. Sample processing question: "What were some dominant themes and similar concerns?"

This workshop provides parents with information and strategies to deal with this transition phase. The July 1985 program at NTID had 16 participants. Parents attending the workshop were asked to respond to a questionnaire (See Attachment B) and the results are cited on the summary evaluation (See Attachment C).

Parents were in general agreement that:

1. A good career education program in high school will better prepare students for a job after high school.

2. When compared to normal-hearing individuals, career development of hearing-impaired people has been unfortunately restricted to certain skill areas.

3. Deaf adolescents need to recognize the importance of college in planning their future.

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4. Teachers should help deaf students to explore a variety of different occupations.

5. Teachers should help deaf students to plan for a career and be prepared to make some realistic career decisions.

6. Teachers should arrange for deaf workers to come to school and talk to students about their job or career.

7. The school should provide career guidance to help students learn about thei own abilities and interests.

8. A college education is equally important for males and females.

9. One's choice of an occupation should take place in the high school or college years.

10. Parents should help their children to make realistic career choices.

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ATTACHMENT A

Question Strips

EXAMPLE: In high school, I was a . . .

1.   A Job I had during high school was . . .

2.   My parents thought I should become . . .

3.   The first Important decision that my parents let me make In high school was . . .

4.   My first experience living away from home was . . .

5.   A responsibility I have given to my adolescent In the past year . . .

6.   My adolescent's greatest strength Is . . .

7.   My biggest worry about sending my son/daughter to college Is . . .

8.   The biggest concern I have In helping my adolescent select a college Is . . .

9.   The best decision I have made for my deaf child was . . .

ATTACHMENT 3

Explore Your Future (EYF) Parent Questionnaire

Directions: Listed below are some common statements regarding vocational learning of children and ways of working with them to expand their career education.   Select the answer which best represents your position.

1. A good vocational education program in high school will better prepare students for a job after high school.

   _____ agree strongly
   _____ agree to some extent
   _____ disagree strongly
   _____ am not certain

2. When compared to normal-hearing individuals, career development of hearing-impaired people:

   _____ is restricted to certain skill areas
   _____ is an identical process
   _____ follows the same general patterns
   _____ relies on special intervention

3. Young people need to recognize the importance of college in planning their future.

   _____ agree strongly
   _____ agree to some extent
   _____ disagree to some extent
   _____ disagree strongly
   _____ I am not certain

4. The major problem for disabled individuals capable and interested in working is:

   _____ employment legislation
   _____ inability to get needed skills
   _____ lack of successful experiences
   _____ underemployment

5. Teachers should help students to explore a variety of different occupations.

   _____ agree
   _____ agree somewhat
   _____ disagree to some extent
   _____ disagree strongly
   _____ am not certain

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6. Teachers should help students to plan for a career and be prepared to make some realistic career decisions.

_____ agree
_____ agree somewhat
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

7. Teachers should help students to select academic and vocational courses to prepare for the eventuality of changing careers.

_____ agree
_____ agree somewhat
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

8. Teachers should arrange for workers to come to school and talk to students about their job or career.

_____ agree
_____ agree somewhat
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

9. The school should provide vocational guidance to help students learn about their own abilities and interests.

_____ agree strongly
_____ agree to some extent
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

10. A college education is equally important for males and females.

_____ agree strongly
_____ agree to some extent
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

11. The main difference between career education and vocational education is:

_____ vocational education includes occupational and career education.
_____ vocational education is included within career education.
_____ there is very little difference between them.
_____ none of the above.

12. The main difference between career development and career education is that:

_____ career education is a subset of career development.
_____ career development is a subset of career education.
_____ there really is no difference between them.
_____ none of the above.

13. One's choice of an occupation should take place in the high school or college years.

_____ agree strongly
_____ agree to some extent
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

14. Parents should help their children to make realistic career choices.

_____ agree strongly
_____ agree to some extent
_____ disagree to some extent
_____ disagree strongly
_____ am not certain

15. Parents should become involved in their children's career development:

_____ at birth
_____ when they enter school
_____ at the junior high school level
_____ at the high school level
_____ not at all

ATTACHMENT C

Summary Evaluation

EYF Parent Transition Workshop

13 July, 1985-NTID

N=16

	Average Ratings (5 highest, 1 lowest)	
	Prior	After workshop
1. My understanding of the workshop objectives . . .	2.7	4.7
Comments: (none)		
2. My level of participation in this workshop . . .		3.3
Comments: (none)		
3. My level of comfort with the workshop atmosphere . . .		4.6
Comments: (none)		
4. My level of interest in this workshop . . .		4.9
5. My level of satisfaction concerning what I expected to learn . . .		4.6
Comments: (none)		

6. What were the "big ideas" or useful content you learned?

Importance of financial ed.
Never thought that the checking account caused such a commotion.
The transition from home life to college life, check book balance, etc.
Student's perspective.
Money management.
Financial and Transition to college life.
Money management at home, i.e., deaf helper!
Had the prior experience at the Co-op programs and was a great follow-up.
Nothing - except perhaps "more" time.
Money management, Gallaudet Prep. Prog.
All parents share the same basic fears.
Information to parents before coming here.

7. What would you like to see changed?

    More time to talk with other parents.
    Nothing that I can think of.
    Nothing.
    Teach the parents perfect sign language, so the deaf sibling can have it
    easier talking English.
    More time for questions.
    Nothing.
    Nothing - except perhaps "more" time.
    More time for questions.
    Get more information to parents so we know what to expect when we get
    here.

8. Did you get your questions answered? If not, what do you need to know?

    Yes.
    Yes.

9. What should we do differently?

    Tell parents ahead of time about content of workshop.
    Tell parents ahead of time that eve prior to program is not planned at
    all for them.
    Forget about the small group question game.
    Talk, Talk, Talk - and be happy to have a deaf child - they are the best
    innocent teachers.
    Nothing.
    Introduce parents to each other.
    A look more at your campus and classroom.

THE ROLE OF THE FAMILY IN THE TRANSITION OF YOUNG HEARING-IMPAIRED ADULTS: THE CASE OF POSTSECONDARY GRADUATES

AFAFE EL-KHIAMI

The role of the family in the transition of young hearing-impaired adults is finally getting the long overdue attention it deserves on the part of researchers and practitioners alike. This paper reports preliminary results from a study of a representative national sample of parents of hearing-impaired recent graduates from 46 postsecondary programs. The parents involvement in the selection of their child's postsecondary program, their visits to campuses, attendance of orientation programs targeted to them, and knowledge and evaluation of available services are discussed. Their perceptions of their children's transition from postsecondary programs to work and the jobs obtained are also presented.

Undeniably, the family plays a major role during an individual's formative years. In the case of a disabled person, the role of the family is even more vital, though different in many ways. The changes in relationships and dynamics among family members brought about by the presence of a disabled child have been well-documented in the literature (Bristol & Schopler, 1983; Dunlap & Hollingsworth, 1977; Faerstein, 1981; Farber & Ryckman, 1965; Featherstone, 1981; Moores, 1973; Parks, 1977). In this respect, the effects of deafness are no different from any other disabling condition. In fact, several researchers have studied and delineated parental reactions to the diagnosis of hearing impairment in their child. Feelings of shock, denial, anger, guilt, and repression are commonly experienced (Hersch & Amon, 1975; Mindel & Vernon, 1969; Schlesinger & Meadows, 1972). Generally, the parents gradually come to terms with the situation and try to adjust and adapt to it. This by no means implies that the impact of the child's deafness on the family is limited to this stage.

Researchers in the field of the family distinguish seven stages in the nuclear family cycle. Most often, the progression from one stage to the next entails a redefinition of roles. This process is usually fraught with stress which persists until the family reaches a new state of equilibrium. This state is achieved as family members arrive at a common understanding and a consensus about their new roles. In other words, concomitant with growth is the likelihood of tension and role conflicts in the average family (Duvall, 1971; Moores, 1973). Moores (1973) further argues that the presence of a handicapped child renders transition between stages even more stressful.

While most of the literature focuses on the handicapped child and the family, there is a dearth of information about the family involvement in major life events of disabled young adults and more particularly nearing-impaired individuals. In this presentation two such events are considered--transition from school to postsecondary program and from a postsecondary program to wcrk.

The results to be presented are preliminary findings from a national study funded by the National Institute of Handicapped Research aiming at polling students, alumni, their parents and vocational rehabilitation counselors about various aspects of postsecondary experiences of hearing-impaired young adults.

PARENTS' SAMPLE

Survey forms were sent to parents of senior students in the classes of 1984 and 1985 in a national sample of postsecondary programs for hearing-impaired persons. The mailing of the forms was contingent upon obtaining the student consent to contact their parents and their parents' address. Two mailings of the questionnaire netted 376 completed forms, a response rate of 61%. To insure that the parents who responded are representative of the parents of the students participating in the study, several comparisons have been made. Figures 1 to 3 indicate very similar percentage distributions by the child type of postsecondary program, child gender, and race between the students and parents projects' samples. However, some of the parents' characteristics slightly differ in both surveys. For example, more hearing mothers (3.9%) and fewer deaf parents participated in the parents' survey (Fig. 4 & 5). In addition, while the percentage distribution in the educational categories of fathers in both surveys remained basically similar (Fig. 6), the parents' project sample included 18.4% more college educated mothers, 16% more mothers with high school degree, and substantially fewer (34.2%) in the below high school educational level (Fig. 7).

The examination of the income distribution of the parents' sample reveals that it approximates a normal distribution with about one-fifth falling in each of the two middle income brackets (Table 1). It should be noted also that over two-thirds (67.3%) of the survey forms were completed by mothers, nearly one-fifth (19.3%) by fathers, and a little more than one-tenth of the forms (11.5%) were completed jointly by both parents. A negligible 1.9% of the respondents were significant others not including the parents, such as grandparents, aunts, uncles, siblings, etc. (Table 2). This data document the participation and involvement of fathers in matters related to their hearing-impaired children. Either separately or jointly with their spouses, 30.8% of the fathers participated in the survey. Several authors (Le Masters,

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REPRESENTATIVENESS OF PARENTS' SURVEY
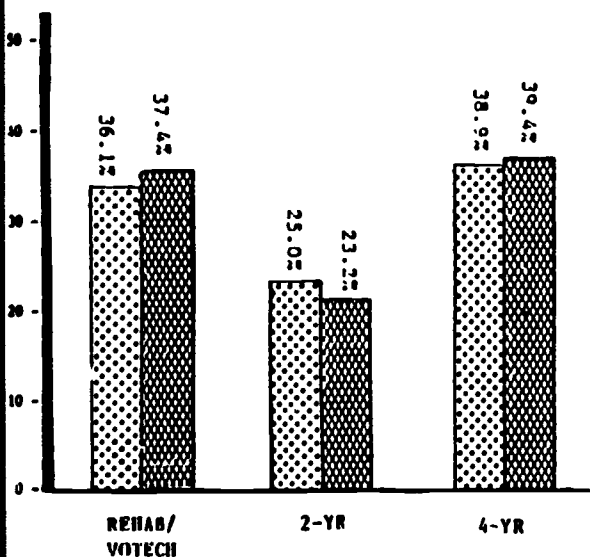
Fig.1 - Students' Type of Program
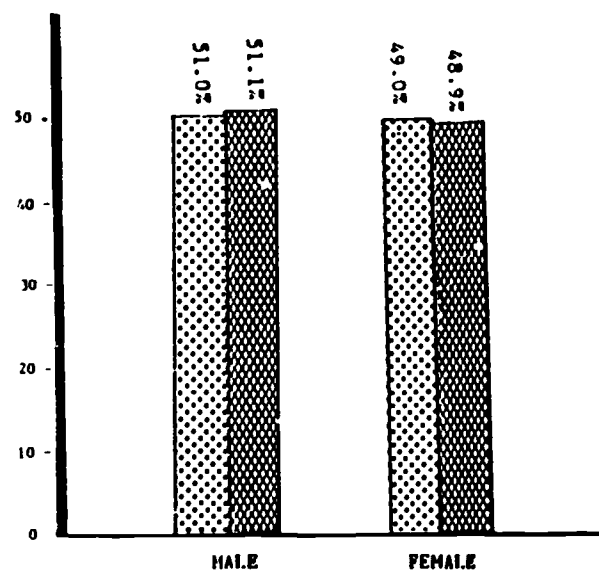
Fig.2 - Students' Gender

Fig.3 - Students' Race

LEGEND
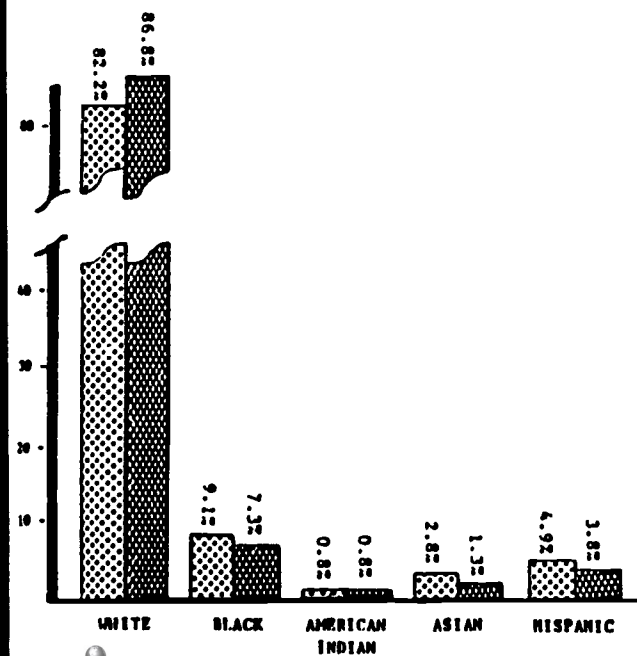
- STUDENTS' SURVEY
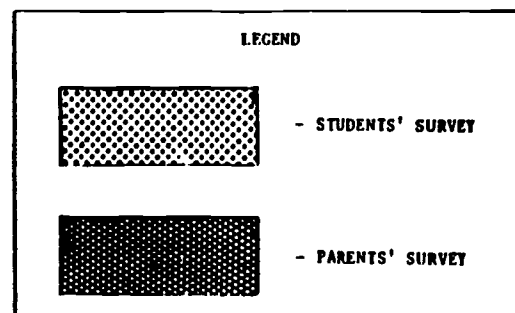
- PARENTS' SURVEY

REPRESENTATIVENESS OF PARENTS' SURVEY
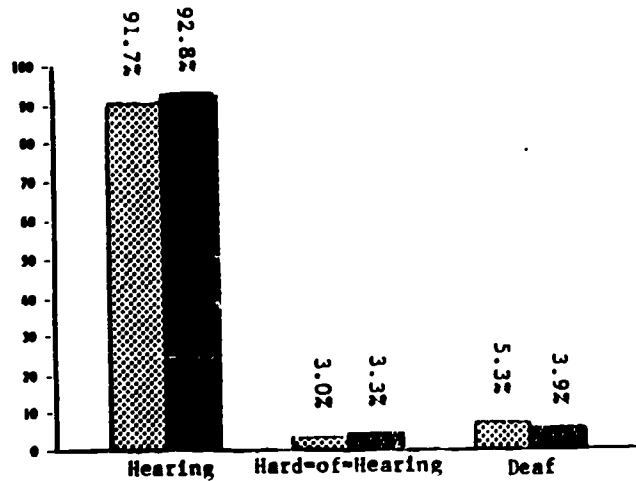
Fig.4 - Father Hearing Status
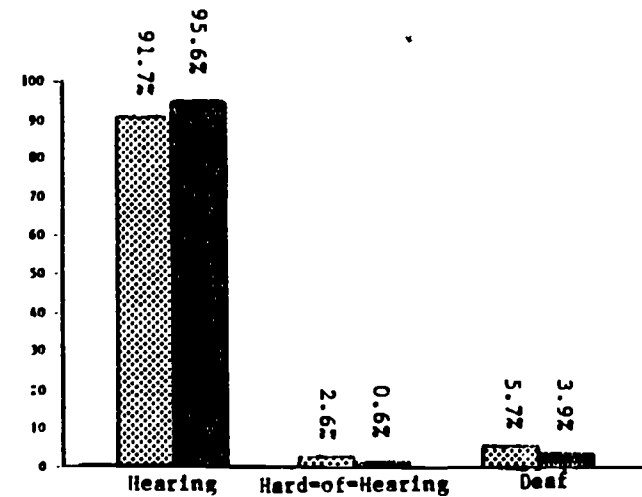
Fig 5 - Mother Hearing Status
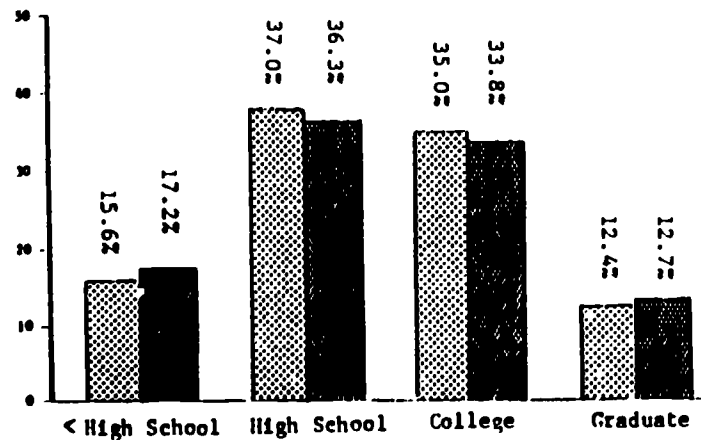
Fig.6 - Father Education
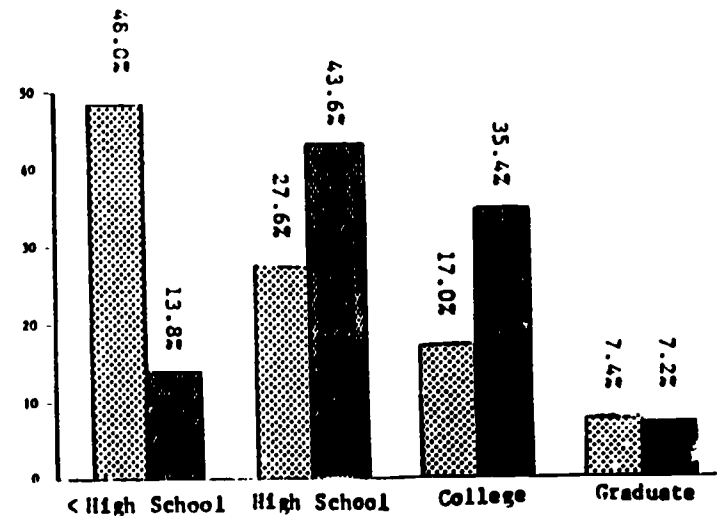
Fig.7 - Mother Education

TABLE 1

Income Distribution

Income Levels	Percent
Below $10,000	12.4
$10,000 - $19,999	15.9
$20,000 - $29,999	21.6
$30,000 - $39,999	21.9
$40,000 - $49,999	11.0
$50,000 +	17.3

1971; Levine, 1965; Meadow, 1969; Price-Bonham, 1978) have pointed out that most studies of parental roles in families with hearing-impaired children have focused their attention almost exclusiveiy on the mother's role. However, researchers, such as Neuhaus, 1969; Russell, 1978; McNell and Chabassol, 1981; and Crowley et al. 1982, have recognized the importance of the role of the father in such families.

TABLE 2

Distribution by Respondents' Relationship to
Postsecondary Students Surveyed

R. Relationship	Percent
Mother	67.3
Father	19.3
Both Parents	11.5
Other	1.9

TRANSITION FROM SCHOOL TO POSTSECONDARY PROGRAMS

The transition from school to postsecondary education represents an important juncture in a person's life in more than one way. It ushers the individual into adulthood, the beginning of independence and determination as to one's life and career objectives. Among the important decisions to be made in this stage is whether or not to enroll in a postsecondary program and the selection of such a program. For hearing-impaired persons and their families, this is a particularly difficult and trying time. For nearly one-third of the hearing-impaired children in the U.S. who are educated in residential schools (AAD, 1980, Table 1, p. 179), graduation from high school marks the beginning of mainstreaming in the hearing world. For the majority of these and other hearing-impaired graduates from different secondary educational settings, going to a postsecondary program means leaving behind the protective and familiar milieu of parents, teachers, and hometowns.

What role do the parents play during this important transition in the life of their hearing-impaired child? In this study, parental influence is assessed through their involvement in the selection of the postsecondary program their child enrolled in; their visit to the campus and attendance in a family orientation program at the school; and finally, their knowledge about the services offered in these programs.

SELECTION OF POSTSECONDARY PROGRAMS

About two-thirds (62.1%) of the parents participating in the survey reported helping in the selection of the postsecondary program of their hearing-impaired child. The question remains as to what are the factors that significantly affect family involvement in the selection of their child's program? Did it vary by the child's gender or type of postsecondary program? An analysis by ander of the child did not reveal any statistica'ly significant differences in the parents' behavior (chi square = 0.0316, d.f. = 1, p = 0.8590). In other words, the extent of parents involvement in the selection of their child's postsecondary program is the same whether it is a son or a daughter. However, parents involvement in the selection of their child's postsecondary program has been found to differ significantly with the type of program their child enrolled in (chi square = 9.285, d.f. = 2, p = 0.0096). Data reported in Table 3 indicate that parents of four-year college students have the highest rate of participation in the selection of the postsecondary program, 71.5% as compared to 54.1% and 56.9% for two-year and rehab-votec program students. The fathers' educational level may account for the differential involvement of parents in the selection of the postsecondary program of their hearing-impaired children. Nearly two-thirds (63.7%) of the fathers of four-year college students are themselves college graduates (Table 3). Their expectations of their children are commensurate with their own personal achievement. Also, higher educational levels are generally associated with a sense of control and mastery over life events and outcomes (Phares, 1957). Parents falling into this group will marshall all their resources—informational, financial, and emotional—to bring about the realization of their expectations for their children.

While education may be viewed by the college educated parents as an additional means for the maintenance of the family social status and its transmission from one generation to another (Bowles & Gintis, 1976), others in the sample consider a good education as the key to a better future for their disabled children. In fact, parents were asked to evaluate the importance of nine factors thought to influence their choice of a postsecondary program for their hearing-impaired child. Data in Table 4 indicate that, although seven of the nine factors were considered as very important by more than 50% of the parents, the factor rated by the largest percentage of parents as very important is the quality of education the child would get (82.5%). It is followed by insuring independence for the child (74.1%), and the availability of good support services (74.0%). The comparison of these factors to those reported by Craig as determining school selection, namely—"career objectives, financial assistance, living arrangeme..ts, and school guidance, as well as proximity" (Craig, 1973:176) provides another indication of the far reaching changes in the educational and social opportunities for hearing-impaired individuals. In the present study, few parents (20.4%) reported program proximity as a very

Important factor in their selection of their hearing-impaired child's post-secondary program.

Additional analyses were performed on each of the nine factors to investi-gate whether or not parents differed significantly in their evaluation depending upon the type of postsecondary program their child was enrolled in. "Closeness to home" and "VR counselor selection" are the two factors which exhibited a statistically significant association with type of postsecondary program (Table 3). For example, about one-third of the parents of students in two-year and in rehab-votec programs attribute more importance to closeness to home of the program (35.7% and 28.4%, respectively) compared to only 7.4% reported by parents of four-year college students. A similarly significant pattern (chi square = 21.072, d.f. = 6, p = 0.0018) is detected in the parents' responses when asked about the importance of the vocational rehabili-tation counselor's influence on postsecondary program selection. More than one-half (55.2%) of the parents of two-year college students and 60.3% of the rehab-votec students viewed the vocational rehabilitation counselor's selec-tion as important and/or very important, while only 34.5% of the parents of four-year college students considered it as such (Table 3). In addition, as previously noted, nearly two-thirds (63.7%) of the fathers of this group of students have a college education and 44.8% of them enjoy an annual family income of $40,000 or more. In comparison, about one-third (31.7%) and a little over one-third (38.5%) of the fathers of students in rehab-votec and two-year programs have been to college. This is reflected in their family income, as only 13.8% and 23.5% of parents having children in the first and second types of programs fall into the $40,000 and over income group (Table 3). A likely interpretation is that, due to their educaticnal levels, parents of students in the four-year postsecondary programs are increasingly aware of the educational options available to their hearing-impaired children. They participate more actively in the selection of the postsecondary program, par-ticularly since they have the income to supplement their hearing-impaired child's educational costs not covered by Vocational Rehabilitation. It is interesting to note that except for these two factors, no others were found to be rated differently in a significant manner by parents of students in each type of postsecondary program.

VISIT TO CAMPUS

Another indicator of the parents involvement and concern at this important juncture of their hearing-impaired child's life is their visit to the campus of the postsecondary program prior to their child's enrollment. Data reported in Table 5 indicate that parents who visited postsecondary campuses consti-tuted 59.8% of the respondents. When analyzed by gender of the child, there were no statistically significant differences in the the rates of parents' visits tu postsecondary programs. This means that, irrespective of whether they have a hearing-impaired son or a hearing-impaired daughter, six out of every ten parents did visit the campus. In addition, no statistically significant differences were found (p = 0.8296) when parents' visits to campuses were crosstabulated by type of postsecondary program. However, results in Table 5 indicate that community colleges were visited slightly more often (62.7%) than the rehab-votec (58.7%) and the four-year programs (59.2%).

TABLE 3

Selected Parents Variables Distribution By Their Hearing-Impaired Children Type of Postsecondary Program

Selected Variables	Re-Votec		2-Year		4-Year	
	N	%	N	%	N	%
Parents Help in Selection						
Yes	78	56.9	46	54.1	105	71.5
No	59	43.1	39	45.9	42	28.5
Chi Square = 9.285 d.f. = 2 p = 0.0096						
Close to Home						
Very Important	21	28.4	15	35.7	7	7.4
Important	16	21.6	10	23.8	6	6.3
Somewhat Important	14	18.9	8	19.0	20	21.1
Not Important	23	31.1	9	21.4	62	65.3
Chi Square = 41.387 d.f. = 6 p = 0.0000						
VR Selection						
Very Important	14	20.6	11	28.9	15	18.5
Important	27	39.7	10	26.3	13	16.0
Somewhat Important	20	29.4	6	15.8	24	29.6
Not Important	7	10.3	11	28.9	29	35.8
Chi Square = 21.072 d.f. = 6 p = 0.0018						
Fathers Education						
Below High School	31	24.6	16	19.3	14	9.6
High School	55	43.7	35	42.2	39	26.7
College	40	31.7	32	38.6	93	63.7
Chi Square = 31.823 d.f. = 4 p = 0.0000						
Family Income						
Below $4,000	5	3.8	2	2.5	---	----
$4,000 - $9,999	23	17.7	4	4.8	9	6.7
$10,000 - $19,999	24	18.5	17	21.0	14	10.3
$20,000 - $29,999	30	23.1	19	23.5	26	19.1
$30,000 - $39,999	30	23.1	20	24.7	26	19.1
$40,000 +	18	13.8	19	23.5	61	44.8
Chi Square = 46.701 d.f. = 12 p = 0.000						

TABLE 4

Parent's Evaluation of Factors Influencing the Selection of a Postsecondary Program

Factors	Very Important	Important	Somewhat Important	Not Important
The program has a good reputation	68.3%	27.6%	3.6%	0.5%
The program matched the child's interests or objectives	71.6%	24.3%	2.7%	1.4%
The program had good support services	74.0%	20.0%	4.6%	1.4%
The program was close to home	20.4%	15.2%	19.9%	44.5%
The child would get a good education	82.5%	15.2%	2.3%	-----
The child would get good job training	70.8%	24.5%	3.2%	1.5%
The child would become independent	74.1%	18.3%	4.9%	2.7%
The child had selected it	53.0%	37.8%	7.8%	1.4%
The VR Counselor recommended it	21.5%	26.7%	26.7%	25.1%

TABLE 5

Effect of Type of Postsecondary Programs and Fathers Characteristics on Campus Visit and Attendance of Orientation

Type of Programs and Fathers Characteristics	Visit/Attendance Yes N	%	No N	%	Total N	%
I. Visit						
Type of Programs						
Total	**220**	**59.8**	**148**	**40.2**	**368**	**100**
Rehab-Votec	81	58.7	57	41.3	138	37.5
2-Year College	52	62.7	31	37.3	83	22.6
4-Year College	87	59.2	60	40.8	147	39.9
Chi Square = 0.3730 d.f. = 2 p = 0.8296						
Visits to 4-Year Colleges						
Father Education						
Total	**86**	**59.7**	**58**	**40.3**	**144**	**100**
Below High School	4	30.8	9	69.2	13	9.0
High School	17	43.6	22	56.4	39	27.1
College	65	70.7	27	29.3	92	63.9
Chi Square = 13.3189 d.f. = 2 p = 0.0013						
Fathers SEI						
Total	**82**	**59.4**	**56**	**40.6**	**138**	**100**
Low	10	37.0	17	63.0	27	19.6
Medium	16	53.3	14	46.7	30	21.7
High	56	69.1	25	30.9	81	58.7
Chi Square = 9.2418 d.f. = 2 p = 0.0098						
II. Attendance of Orientation						
Type of Programs						
Total	**135**	**72.6**	**51**	**27.4**	**186**	**100**
Rehab-Votec	46	76.7	14	23.3	60	32.2
2-Year College	31	73.8	11	26.2	42	22.6
4-Year College	58	69.0	26	51.0	84	45.2
Chi Square = 1.0620 d.f. = 2 p = 0.5580						
Attendance of 4-Year College Orientations						
Fathers SEI						
Total	**57**	**71.3**	**23**	**28.8**	**80**	**100**
Low	13	92.9	1	7.1	14	17.5
Medium	12	80.0	3	20.0	15	18.8
High	32	62.7	19	37.3	51	63.8
Chi Square = 5.5523 d.f. = 2 p = 0.0623						

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Did any of the parents' characteristics affect their visit to campuses? In social stratification studies, it has been customary to use the father's socioeconomic characteristics as indicators of the social status of the family as a whole. This practice has been followed in this study, though mothers constitute the majority of the declared respondents of the parents survey. Two such characteristics have been used as measures of the family life style. The first is the father's educational level and the second is the father's Socioeconomic Index (SEI) score. Developed by Duncan (1961), the Socioecomic Index is a composite measure which combines education, occupation and income. Visits to campuses were not found to be significantly affected by either father's education or father's SEI. However, when type of postsecondary program were controlled for, the above mentioned relationships remained non-significant only for rehab-votec and two-year programs. Parents' visits to four-year colleges were found to be significantly associated with father's educational level (chi square = 13.3189, d.f. = 2, p = 0.0013). Results reported in Table 5 show that father's SEI had also a significant effect (chi square = 9.2418, d.f. = 2, p = 0.0098). Seven out of ten fathers with high SEI, planning to send their children to a four-year college, visited the campus as compared to five out of ten fathers with middle SEI scores and four out of ten fathers with low SEI. Needless to say, what accounts for these differentials may be attributed, in large part, to costs of travel.

KNOWLEDGE AND ATTENDANCE OF PARENTS' ORIENTATION

Other indicators of parents involvement in the education of their hearing-impaired children are knowledge and attendance at parents' orientation programs organized by the various schools. More than one-half (53.7%) of the parents knew about these programs, if indeed offered at the various campuses. Type of postsecondary programs, child gender, father's education, and father's SEI did not affect this knowledge. This can be interpreted as another sure sign of the parents' involvement and concern with their hearing-impaired child's well-being, irrespective of the group they or their children fell under in the aforementioned variables.

Of the parents who knew about the availability of orientation programs especially organized for their benefit, 72.6% of them attended the orientation. Although no statistically significant differences in parents attendance rates have been detected when examined by type of postsecondary programs, child's gender, father's education or fathers' SEI, an interesting finding is to be noted. When the association between attendance of parents' orientation and fathers' SEI was analyzed within each type of postsecondary program, the relationship was found to be of marginal significance (p = 0.0623) for the four-year college type of program. While the expectation is toward a positive association, i.e. the higher the SEI, the higher the attendance rate, the data in Table 5 support a negative association with 93% of fathers with low SEI attending, 80% of fathers with medium SEI, and only 63% of those with high SEI. At first glance, these results may be viewed as indicating that highly educated, well-to-do fathers who occupy high status jobs are likely to be less involved in their hearing-impaired children's education compared to other fathers. However, this will be an erroneous conclusion to draw from these findings. What seems to be a more plausible interpretation is that the very demands of high status jobs and life styles of these fathers

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dictate their schedule and may prevent them from attending organized events such as parents' orientation. However, their involvement and interest in their hearing-impaired children's well-being is well-documented by their higher rate of visits to four-year college campuses referred to in the pre-ceeding section. As for the 93% and 80% attendance rates of fathers with low and medium SEI, it is easily explained by the pride they feel in the accomplishments of their disabled children. Furthermore, attendance at the parents' orientation which may be at a financial burden to them, gives them a chance to personally insure that their hearing-impaired children will be cared for adequately.

PARENTS' KNOWLEDGE AND PERCEPTIONS OF SERVICES

A final indicator which reflects parental concern with their children's postser.ndary education is their knowledge of services available in these progr.ms. Parents were also asked about their perceptions as to the impor-tance of thirteen services in postsecondary education programs for hearing-impaired students. Data presented in Table 6 show that services deemed very important by most parents are interpreting services (81.5%), career counseling and placement services (76.3%), speech and hearing services (74.5%), and per-sonal counseling services (74.0%) to name the top four. While results reported in this table indicate that parents' knowledge about the availability of services is adequate, there seems to be a relationship between the percen-tage of "don't know" and the importance of the service as perceived by the parents. For example, the services previously mentioned as very important by most parents have a relatively small percentage of parents not knowing about their availability. The percentages of "don't know" for these services range from 5.4% to 12.8%. Transportation and help in finding off-campus housing which are perceived by very few of the parents as very important (24.3% and 31.8%, respectively) exhibit the highest percentages of "don't know"--31.0% and 43.2%, respectively.

TRANSITION FROM SCHOOL TO WORK

The hearing-impaired children of six out of every ten parents surveyed graduated from the postsecondary program they enrolled in and the children of three out of the remaining four parents were about to do so. The hearing-impaired child of the latter group has a 50/50 chance to either transfer to another program or drop out completely. Percentagewise, it means that at this late stage of postsecondary education the dropout rate is about 5.0% and so is the rate of transfer to another program. However, it should be stressed that these rates hold only for hearing-impaired students who are about to graduate. In these instances, it is reasonable to assume that dropping out or trans-ferring to another program is caused by other than academic factors.

Do graduation rates, as reported by the parents differ by type of program or by students' gender? As graduation rates are examined by type of post-secondary program, a statistically significant difference is detected (chi square = 16.41378, d.f. = 2, p = 0.0003). Four-year colleges report the highest graduation rate (70.5%), followed by the rehab-votec (59.4%), and finally, the two-year community colleges (43.5%).

TABLE 6

Parents Knowledge and Perceptions of Services

Services	Available			Importance			
	Yes %	No %	Don't Know %	Very Important %	Important %	Somewhat Important %	Not Important %
Personal Counseling Services	93.5	1.1	5.4	74.0	22.8	2.6	0.6
Speech & Hearing Services	81.4	6.3	12.3	74.5	17.9	4.9	2.7
Social Activities	81.9	5.4	12.7	47.4	34.8	13.0	4.8
Student Health Services	69.9	9.6	20.6	52.3	30.8	12.3	4.6
Financial Aid Services	86.9	3.1	10.0	61.6	24.0	9.5	4.9
Career Counseling & Placement Services	83.1	4.1	12.8	76.3	19.5	2.7	1.5
Transpoı ation Services	31.0	38.0	31.0	24.3	26.4	25.7	23.6
Interpreting Services	93.0	1.4	5.6	81.5	12.9	3.5	2.1
Tutoring	65.0	5.7	29.3	65.9	23.2	7.6	3.3.
Notetaking Services	61.5	5.5	32.9	63.3	22.6	9.2	4.9
Special Telephone/ TTy Services	87.6	4.2	8.2	63.8	27.3	6.1	2.8
On-Campus Supervised Housing	63.2	28.2	8.6	50.5	20.9	15.3	13.3
Help in Finding Off-Campus Housing	37.6	19.2	43.2	31.8	29.1	19.8	19.4

It is Interesting to note that although parents are reporting on a similar male/female ratio than in the student population surveyed (Fig. 1), the gender distribution of graduates in the three types of postsecondary programs differ. Females are underrepresented by 8.6% in the rehab-votec programs and by 15.2% in the two-year community colleges. However, they are overrepresented by 12.4% in the four-year colleges. It should be noted that gender differences in graduation rates are not large enough to render them statistically significant overall or within each of the three types of postsecondary programs.

EMPLOYMENT

When parents were asked about the employment status of their hearing-impaired children, 63.1% of the parents reported that their children found employment right after graduation from a postsecondary program. Furthermore, the vast majority of the employed (87.9%) retained their Jobs. Of those who became unemployed (12.1%), one-half i.e. 6% were laid-off and one-third (4%) left their Job for personal reasons, such as to continue their education or to raise a family.

What is the effect of type of postsecondary program and gender on postgraduation employment rates? The effect of type of postsecondary programs on the employment rate of hearing-impaired graduates is of marginal statistical significance (chi square - 7.4624, d.f. - 2, p - 0.0240). In this sample, graduates of two-year colleges experience the highest rate of employment (71.8%), followed closely by four-year colleges (69.t ,, and finally, by the alumni of rehab-votec programs (51.8%). With regard to gender, no statistically significant differences are detected in the distribution of postgraduation employment rates of males and females. However, as this association is considered within each type of postsecondary program, a marginally significant effect of gender is observed among the four-year college graduates (chi square - 4.2808, d.f. - 2, p - 0.0385). In fact, although hearing-impaired males graduating from the four-year programs are 12.4% fewer than the hearing-impaired females, as pointed out before; 83.3% of the males found Jobs right after graduation as compared to only 60.7% of the females.

PARENTS' PERCEPTIONS OF THEIR CHILDREN'S EMPLOYMENT

Parents were asked about their perceptions of the Jobs their hearing-impaired children obtained after graduation from a postsecondary program. Three out of four parents expressed satisfaction, leaving only one not pleased with the child's Job placement. The reasons most frequently mentioned by the first group of parents are: "matches the child's interest and training," "a good Job," "provides exper.ence," "offers opportunities for advancement," and "promotes independence." Dissatisfied parents report most frequently that the Job: "does not match the interest or training of their child," "only a part-time Job," "a Job with no future," "not lucrative or too difficult." When these reasons are tabulated by type of programs, no statistically significant differences were detected; however, the ranking of the reasons from most to least frequently mentioned, changed slightly.

CONCLUSION

The results presented thus far conjure in our minds an image of the role of the family very different from what the literature on deaf adolescents and their families leads us to expect. Undoubtedly, the presence of a disabled child can be and is usually stressful on the family and the child alike. However, it seems that researchers, in their attempts to study and alleviate this stress, have lost sight of the natural process of adjustment. Maybe this process is too slow to be noticeable or even too slow to rely on for effective coping. As a result, researchers have been preoccupied with this first stage at the expense of later and equally important stages. This, in turn, due to lack of information more than anything else, helped imply that issues and problems in the family life of hearing-impaired adolescents will carry on into the life of hearing-impaired young adults.

It would be foolish not to recognize that many families fail to manage the stress created by the presence of a disabled child in their midst, leaving the parents each going their separate ways. Although, nowhere in the survey instrument is information solicited on family relationships, some parents made comments documenting this fact. Sometimes, the disabled child was reared by grandparents or other relatives. Irrespective of who is the "acting" parent, the responses received indicated that this stage of the young hearing-impaired adult's life is characterized by care, concern and involvement on the part of the parent. And, I dare say, in many instances, a lot of pride in the child's accomplishments as attested to by additional comments and personal letters received.

It may be argued that the study sample may be biased toward adjusted families of hearing-impaired adults on two counts. First, only students with good rapport with their families provided their parents' addresses. Second, only concerned parents answered the survey. However, the representativeness of the parents' sample compared to information supplied by the students surveyed about their parents, as discussed earlier, serves to refute both of these counts.

To sum up, the data reported and discussed in this presentation indicate that the family does indeed play an important role in the transition of hearing-impaired adolescents as they embark into adult life. This role is all the more important as it comes at a critical junction of life—the choice of a postsecondary program which, in turn, determines the entire career of the individual. The parents active participation in the selection of the program attended by their child is well-demonstrated by their visits to campuses and their attendance at parents' orientation programs. Cost of these trips to the various postsecondary programs did not act as a deterrent, particulary to parents with limited financial resources whose hearing-impaired children enrolled in four-year colleges. Results also indicate that the gender of the hearing-impaired child did not affect the parents' behavior in any way. Furthermore, more parents of four-year college students have been involved in the selection of the postsecondary program of their hearing-impaired child (71.5%) compared to those of two-year college students (54.1%) or rehab-voted students (56.9%). In addition, parents of four-year college graduates more than those of other postsecondary graduates, felt that the proximity of the

program or the vocational counselor's choice of postsecondary program as not critical in the selection of the program their hearing-impaired child enrolled in. It should be noted that this group of parents includes the highest percentages of college graduates and of those who enjoy an annual family income of $40,000 or more.

Finally, these results reflect the parents' involvement in the postsecondary education of their hearing-impaired children. This involvement can be fostered through constant dialogues between the parents and the child's counselors at school and at vocational rehabilitation. By keeping the parents abreast of their hearing-impaired child's progress and options, the parents can make informed decisions and be active participants in the rehabilitation process. This can only increase the satisfaction expressed by the majority of the parents with the vocational achievements of their children.

In view of these finding, postsecondary programs need to consider increasing their contacts with the parents and target them along with Vocational Rehabilitation in their recruitment efforts.

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THE EDUCATIONAL AND OCCUPATIONAL ASPIRATIONS AND ATTAINMENTS OF DEAF STUDENTS AND ALUMNI OF POSTSECONDARY PROGRAMS

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This paper presents some results from two research projects. One is a study of 743 deaf students who were expected to graduate from 41 special postsecondary education programs across the United States during 1984 or 1985. The other study is a follow-up survey of 193 deaf respondents in the class of 1984 who were contacted after their graduation. The demographic and auditory characteristics of the prospective graduates are described, as are their oral and manual communication competencies. The types of postsecondary programs attended by these deaf students and their reasons for selecting them are examined. Patterns in amount of encouragement to attend college are assessed, as are the educational attainments of the classes of 1984 and 1985. Information on types of majors and reasons for selecting them are presented. The occupational plans as well as the educational and occupational aspirations of respondents are also scrutinized. Results from the alumni follow-up study focus upon their employment status, occupational attainments, and selected attitudes towards their postsecondary program.

Completing postsecondary training to obtain employment and economic independence are important outcomes in the transition from adolescence to adulthood. Young adults entering higher education need to make several important decisions in order to achieve these goals. They need to decide what kind of career they want, the training needed to enter that career, and where that training can be acquired. Underlying these decisions are the individual's educational and occupational aspirations. These aspirations are created and modified through social interaction. A college student, for example, assesses his or her potential as demonstrated by intelligence and academic abilities.

Significant others such as parents or teachers also appraise these attributes of the student and communicate corresponding expectations which influence the student's aspirations. Research into how these aspirations and expectations are formed have been aided by the contributions of social psychologists such as Cooley (1964) and Mead (1964) who considered that the individual's self-concept developed through social interaction with significant other individuals such as parents, teachers, and peers. A relevant contribution was made by Super (1957) who observed that an individual's self-concept was expressed through selection of an occupation or career.

These perspectives have guided this research study of the educational and occupational aspirations and attainments of deaf youth. This paper presents some results from this research. The objectives of this paper are: (1) To describe key characteristics of a sample of deaf students who were expected to graduate during 1984 or 1985 from special postsecondary educational programs across the United States. Specifically, the sociodemographic and deafness-related attributes of these prospective graduates will be described, as are their oral and manual communication abilities and geographical distribution. (2) To describe key decisions these students made during their education to prepare for employment: What were the programs they attended and why did they select these programs? Who influenced their decision to attend college? What were their majors and reasons for selecting these majors? What were their occupational plans after graduation and what were their future educational and occupational aspirations? (3) To describe the activities pursued by deaf alumni after their postsecondary graduation. How many were employed, unemployed, or still in school? In what kinds of occupations were they working?

METHODS

Data from two research projects are presented in this paper. Data collection methods for each of these projects are discussed below.

Current student study. The target population for this study included deaf students in their last year of training during the 1984 or 1985 school years at 41 special postsecondary programs in 23 states and the District of Columbia. These 41 programs were listed in the 1983 edition of College and Career Programs for Deaf Students (Rawlings, Karchmer, & DeCaro, 1983). Each program had a minimum enrollment of 15 or more hearing-impaired students receiving special support services provided by trained personnel. Project staff visited most of these programs during the spring of 1984 and again in the autumn of 1984, while program staff collected data at the few campuses not visited by project staff. Questionnaires were typically administered to small groups of deaf students. Codable questionnaires were completed by 43.6% of the estimated 1703 eligible prospective graduates in the classes of 1984 and 1985. As shown in Table 1, 14.5% of the respondents were from three rehabilitation facilities, 21.6% from seven technical institutes, 25.0% from 22 community colleges, and 38.9% from nine four-year colleges with or without graduate schools. Community colleges comprised more than half of the 41 post-secondary programs cooperating with the project. As shown in Table 1, there was an average of 18 deaf respondents from each of the participating programs. The community colleges as a group, however, had an average of only eight

respondents per program. This indicates that the community colleges had much smaller enrollments of deaf students compared to the other three types of postsecondary programs. The names of the 41 programs are given in Appendix A.

TABLE 1

Percent Distribution of Respondents in Classes of 1984 and 1985
by Type of Postsecondary Program

			Respondents	
Type of Program	N	Percent	Average Number Per Program Type
3 Rehabilitation Facilities	108	14.5	36.0
7 Technical Institutes	160	21.6	22.8
22 Community Colleges	186	25 0	8.4
9 Four-Year Colleges	289	38.9	32.i
41 Programs	743	100.0	18.1

Alumni study. When project scaff met the class of 1984 on campus during the spring of 1984, their informed consent was requested for their cooperation in a follow-up study approximately one year after their graduation. Ninety-two percent, or 343 of the 371 students in the class of 1984, agreed to cooperate. At that time these cooperating students were asked to provide addresses of their parents, relatives, and other persons who may know their location in 1985. Three mailings of a tracer form between July, 1985 and January, 1986 successfully located 86.3% of the 343 deaf alumni in the class of 1984. Once located these alumni were then sent a survey questionnaire. Three mailings of the survey form were done between August, 1985 and February, 1986. Completed questionnaires were received from 65.2% of the 296 deaf alumni in the class of 1984 who were successfully traced.

RESULTS

Current Student Study

Student characteristics. Key demographic and disability characteristics of respondents are summarized in Table 2. Eighty-four percent of the students became deaf before four years of age, thus can be described as prelingually deafened. Among the 12% of students reporting an additional disability besides deafness, blindness or impaired vision were the leading category, followed by physical disabilities (e.g., cerebral palsy, orthopedic impairments), and then chronic disorders such as asthma, heart trouble, and arthritis. More than half of the deaf respondents graduated from nonresidential high schools, which includes day programs, day classes, and mainstreamed

schools. Eighty-two percent of the students are White and 51% are male. Respondents are generally young; the median age is 22 years.

TABLE 2

Percent Distribution of Selected Characteristics of Respondents, Classes of 1984 and 1985

Characteristic	N	Percent
Age at Onset	705	100.0
Born deaf	445	63.0
Less than 1 year old	65	9.2
1 to 3 years old	83	11.8
3 to 6 years old	57	8.1
6 years and older	55	7.9
Additional disability	717	100.0
Yes	87	12.1
No	630	87.9
Type of High School	699	100.0
Residential	312	44.6
Nonresidential	387	55.4
Race	738	100.0
White	608	82.4
Black	67	9.1
Hispanic	36	4.9
Asian, American Indian	27	3.6
Gender	739	100.0
Male	377	51.0
Female	362	49.0
Age	727	100.0
18-19	52	7.2
20-21	219	30.1
22-23	177	24.3
24-29	207	28.5
30-61	72	9.9

Communication competencies. As shown in Table 3, a majority of the deaf respondents evaluated their manual communication skills better than their oral communication skills. While 82% rated their expressive and receptive signing competencies as either very good or good, between 61% and 64% considered their speech and speech reading to be very good or good. Seventy-three percent rated their fingerspelling as good or better. It is also interesting to note that about 4% had no or poor signing skills, while 14% reported no or poor speech skills. Deaf adults in the 1971 National Census of the Deaf Population

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also evaluated their manual communication skills better than they did their oral skills (Schroedel, 1976/1977). However, several studies of hearing-impaired college students and alumni reported different patterns in ratings of communications skills. At NTID the ratings of newly enrolled deaf students' expressive speech skills were as good as their ratings of their abilities to understand sign language (McKee, Stinson, & Blake, 1984). In another study, deaf persons educated in regular colleges and universities reported more intelligible speech than deaf persons educated in special colleges (Schroedel, In press). It may be inferred from these studies that deaf students with different communication competencies attend different types of postsecondary programs.

TABLE 3

Percent Distribution of Respondents' Ratings of Their Oral and Manual
Communication Skills, Classes of 1984 and 1985

Communication Skill		Ratings				
	Total	Very Good	Good	Fair	Poor	None
Use Sign Language	100.0	49.7	33.7	12.9	2.3	1.4
Understand Sign Language	100.0	47.6	34.2	13.6	3.0	1.6
Fingerspelling	100.0	36.4	36.4	18.9	6.3	1.9
Speech	100.0	27.6	33.3	25.2	7.5	6.4
Speech Reading	100.0	26.1	37.9	27.0	6.9	2.1

Such statistically significant patterns occurred with the postsecondary classes of 1984 and 1985. Comparisons were made of students' ratings of five communication competencies (expressive signing, understanding signing, speech, speech reading, and fingerspelling) by type of postsecondary program attended (rehabilitation facilities, technical institutes, community colleges, and four-year colleges). The results indicated that the percentages of deaf respondents evaluating their speech, speech reading, understanding sign language, and fingerspelling as very good increased according to the level of the postsecondary program attended. Thus, larger proportions of deaf students at the community colleges and four-year colleges reported better oral and manual communication competencies than did deaf students at the rehabilitation and technical training programs. These results tentatively suggest that deaf youth who are more communicatively competent receive an academic postsecondary education rather than technical-vocational training. However, other differences in the background characteristics of the deaf students attending the four types of postsecondary programs may also be related to these patterns in communicative skills by type of postsecondary program attended. Identification of specific reasons for these patterns require further study.

Geographic distributions. Students in the classes of 1984 and 1985 origi-
nated from 47 different states and several territories. They attended 41
postsecondary training programs in 23 states and the District of Columbia.
The 50 states and several territories are organized into 10 federal regions.
The distributions of these states by regions where the respondent graduated
from high school and where the student attended a postsecondary program are
given in Table 4. More than 30% of respondents came from the North Central
region and were also educated in this region. The fact that 12 of the 41
postsecondary programs are in the North Central region partially explains this
clustering.

TABLE 4

Percent Distribution of Geographic Region of High Schools and
Postsecondary Programs Attended by Respondents
in the Classes of 1984 and 1985

Region[a]		(1) High Schools	(2) Postsecondary Programs	(1-2) Net Difference
(1)	New England	5.0	.1	-4.9
(2)	New York, New Jersey	7.9	19.9	+12.0
(3)	Mid-Atlantic	8.2	12.5	+4.3
(4)	South East	9.0	7.0	-2.0
(5)	North Central	36.1	31.1	-5.0
(6)	South Central	9.2	7.7	-1.5
(7)	Middle West	7.3	5.4	-1.9
(8)	Rocky Mountains	4.0	1.5	-2.5
(9)	Pacific Coast	10.9	10.2	-.7
(10)	North West	2.4	4.6	+2.2
	Total	100.0	100.0	
	N	698	743	

[a] states by region: (1) CT, ME, MA, NH, RI, VT (2) NJ, NY, PR, VI (3) DE, MD,
PA, VA, WV, DC (4) AL, FL, GA, KY, MS, NC, SC, TN (5) IN, IL, MI, MN, OH, WI
(6) AR, LA, NM, OK, TX (7) IA, KS, MO, NE (8) CO, MT, ND, SD, UT, WY (9) AZ,
CA, HI, NV (10) AK, ID, OR, WA.

It is known that 48% of the 743 deaf respondents in the classes of 1984 and 1985 received their postsecondary raining in the same state where they graduated from high school; 52% were trained outside of their native state. The column of data on the right side of Table 4 expresses these patterns on a regional basis. In 3 of the 10 regions, the number of deaf students receiving postsecondary training surpassed the number of deaf students who graduated from high schools within the region. The location of a federally supported postsecondary program in each of these regions—NTID (New York), Gallaudet College (Mid Atlantic), and Seattle Community College (North West)—is a major factor in these results. Among the seven other regions with a net loss of deaf youth to other regions for postsecondary training, the Pacific Coast had the lowest net difference partially because of the location of a fourth federally funded program (California State University at Northridge) within this region. A fifth federally assisted program, St. Paul TVI is located in the North Central region.

Reasons for selecting program. The deaf students were asked to name the reason why they selected their postsecondary program. As shown in Table 5, most respondents stated that to get either a good education or good job training were the most important reasons for choosing their school. Recommendation about the program from parents, counselors or other persons were relatively less influential. These results were similar to a 1964 study of 457 deaf adults educated in regular colleges and universitites. Rankings in their stated reasons for attending college were: to get good job training (50%), to get a good general education (43%), to learn how to get along with people (5%), and to have a good time (2%) (Quigley, Jenne, & Phillips, 1968).

Encouragement to attend college. The deaf students in the classes of 1984 and 1985 also indicated how much encouragement to attend college they received from different "significant others." Fifty-five percent reported that their mothers expressed a lot of encouragement while 43% stated that their fathers gave them a lot of encouragement (Table 6). That mothers may be more influential than fathers in this respect may be related to the general demographic trend of increases in the number of households with single parents, which usually means that the mother raises the children in such homes (Kelley, 1985). The deaf respondents also reported that high school teachers or counselors and rehabilitation counselors gave less encouragement than their parents to attend college. Smaller proportions of the deaf students reported getting a lot of encouragement from friends, other relatives, clergymen, or employers. Similar results were found by the Quigley group (1968) in a study of deaf college students and alumni who indicated that parents, pre-college counselors or teachers, friends, and relatives were in that order the most to least influential in their decision to go to college.

One interpretation of these findings is that parents are more of a primary referent group than are professional personnel or others in encouraging their deaf sons and daughters to obtain more education. However, parents vary in their expression of this encouragement. Other analyses determined that deaf students from community colleges or four-year colleges were significantly more likely to obtain a lot of encouragement from their fathers than were deaf students from the rehabilitation facilities or technical institutes. Mothers of deaf students from four-year colleges significantly conveyed a lot of

TABLE 5

Percent Distribution of Reasons for Selecting Program by Type of Postsecondary Program, Classes of 1984 and 1985

Reason	Percent
Get a good education	62.6
Get good job training	4.54
People recommended it	17.2
Become independent	14.5
To make friends	14.1
Program is close to home	12.2
Parents recommended it	10.1
VR counselor recommended it	9.6
Number of students	743

NOTE: Total exceeds 100% due to multiple responses.

encouragement than in mothers of deaf students from the other three types of programs. Relevant to these patterns it is also known that significantly larger proportions of deaf students from the community colleges and four-year colleges had fathers with a college education than did deaf students from the rehabilitation-technical programs. Additionally, deaf students from the four-year colleges were significantly more likely to have college-educated mothers than were deaf students from the other three types of postsecondary programs. It is also known that college-educated parents were more apt to convey a lot of encouragement to their deaf sons and daughters to attend college than are parents without a college education. Furthermore college-educated parents prefer than their deaf offspring receive an academic, rather than nonacademic postsecondary education.

Level of current degree. Students also identified the level of the degree they expected to receive upon graduation in 1984 or 1985. Nearly 76% anticipated graduating with a degree below the bachelors (Table 7). Other surveys of deaf adults (e.g., Schroedel, 1976/1977, 1982) reported similar results. Comparatively, 29% of college degrees awarded to the general population in 1980 were the associate's or equivalent two-year degrees (U.S. Bureau of the Census, 1981). One evident reason for this is that most hearing-impaired students aspire to enter occupations which require two years of college, rather than four years. Additionally, deaf college students require more time to complete their degrees than do college students who hear. Research at NTID

TABLE 6

Percent Distribution of Amount of Encouragement to Attend College from Six Sources Given to Respondents, Classes of 1984 and 1985

Source	Total	Amount of Encouragement			
		A Lot	Some	A Little	None
Mothers	100.0	55.5	21.9	11.9	10.7
Fathers	100.0	43.3	21.8	13.2	21.7
High School Teachers, Counselors	100.0	41.3	30.6	10.8	17.3
VR Counselors	100.0	36.8	27.9	14.5	20.8
Friends	100.0	29.5	34.4	18.5	17.5
Others[a]	100.0	22.9	20.1	19.0	38.0

[a] Includes employers, other relatives, clergy.

determined that the average deaf student there needed almost four years to complete an associates's degree (DiLorenzo & Welsh, 1981a). The need for remedial education to reduce academic deficiencies clearly contributes to this extension of postsecondary education.

TABLE 7

Percent Distribution of Level of Current Degree Sought by Respondents, Classes of 1984 and 1985

Degree Level	N	Percent
Vocational diploma, certificate	360	49.2
Associates	194	26.5
Bachelors	136	18.6
Masters	39	5.3
Doctorate	3	.4
	732	100.0

Major field of training. The 743 prospective graduates in this study were majoring in 163 different fields grouped into 23 clusters within five broad areas in Table 8. Two-thirds of these students were majoring in technological, scientific, liberal arts, human services, or clerical areas expected to lead to white-collar employment after graduation. The other one-third of respondents were receiving training in such blue-collar fields as the crafts

TABLE 8

Percent Distribution of Majors and Training Areas
for Current Degree Sought by Respondents,
Classes of 1984 and 1985

Majors	N	Percent
A. Technological or Scientific	(222)	(30.2)
Computer Sciences	61	8.3
Business Management	41	5.6
Drafting, Graphic Arts	41	5.6
Engineering/Scientific Technologies	38	5.2
Health Technologies	18	2.4
Life and Physical Sciences	13	1.8
Natural Resources, Agriculture	6	.8
Engineering	4	.5
B. Liberal Arts or Human Services	(159)	(21.6)
Liberal Arts, Humanities	53	7.2
Education	46	6.2
Human Services	41	5.6
Communications, Media	10	1.4
Home Economics, Consumer Education	9	1.2
C. Office and Clerical Practices	(109)	(14.8)
D. Crafts	(131)	(17.8)
Printing	46	6.3
Auto Body, Engine Mechanics	32	4.3
Machine Trades	31	4.2
Product Services/Repair	13	1.8
Construction	9	1.2
E. Service Workers, Other	(115)	(15.6)
Prevocational	77	10.5
Personal/Domestic Services	14	1.9
Attendants: School, Social Services	12	1.6
Hospitality and Recreation	12	1.6
Total	736	100.0

or semi-skilled services work. Clerical/office practices, computer science, the liberal arts/humanities, printing, and education were among the leading majors selected by respondents. The 10% of students in prevocational training were prospective graduates of a rehabilitation facility that provided their deaf students with work experiences in a variety of occupations, a procedure similar to job sampling. It is worthwhile to note that more deaf students were in training to become engineering or scientific technicians (5.2%) than were expected to become engineers or scientists (2.3%). Likewise, while 2.4% were being trained as health technicians, none were in training to enter the health professions. When asked to specify why they selected their majors, 58% named a job-related reason (see Table 9).

TABLE 9

Percent Distribution of Reasons for Selecting Major
Classes of 1984 and 1985

Reason	Percent
Job-Related Reasons	(58.0)
To work at a specific job	20.0
To get a good job	18.0
To learn job skills	11.0
To work with deaf people	7.0
To improve income	2.0
Other Reasons	(42.0)
Interest in the field	27.0
Have abilities in the field	9.0
To get a better education	6.0
(N=670) Total	100.0

Planned occupation. As shown in Table 10, 42% planned to enter a professional or technical occupation after graduation. Other analyses found that most of these jobs were as technicians or less prestigious professional jobs in teaching, computer programming, drafting, social work, and counseling rather than higher level professional occupations such as law, medicine, dentistry, banking, or architecture. In another study of 1700 deaf adults in professional, managerial, or technical occupations Schroedel (in press) reported deaf workers underrepresented in these high level occupations compared to the proportions of hearing persons working in these occupations.

Compared to the occupations of their fathers and mothers, also given in Table 10, relatively few deaf respondents planned careers in management or sales. Most of the students planning to enter clerical jobs were females. Additional comparisons revealed that the planned careers of the deaf respondents were overall higher in occupational status than were the occupations of their parents. This result is closely related to the fact that all of the deaf respondents have a postsecondary education compared to the 47% of their fathers and 35% of their mothers who were college educated.

TABLE 10

Percent Distribution of Respondents' Planned Occupation
and Fathers' and Mothers' Occupation,
Classes of 1984 and 1985

Occupational Group	Planned Occupation	Father	Mother
Professional and Technical	42.2	23.3	23.0
Managerial	2.3	19.0	7.3
Sales Workers	.1	7.0	7.5
Clerical Workers	24.8	4.5	32.5
Craftsmen	16.6	20.0	2.3
Machine and Transit Operatives	6.4	14.5	9.5
Farmers and Laborers[a]	1.3	7.5	1.4
Service and Household Workers	6.3	5.2	16.5
Total	100.0	100.0	100.0
N	671	629	492[b]

[a] Includes farm and nonfarm laborers.
[b] One hundred and seventy-one mothers were reported as not working.

Expectations for the type of occupation planned after graduation were closely related to the type of major the students were receiving training. Sixty-nine percent planned to enter a white-collar job after graduation in a professional, technical, managerial, sales, or clerical occupation (Table 10), while 66% were majoring in a white-collar field (Table 8). In addition, 16.6% planned to enter an occupation in the skilled crafts after graduation while 14.8% were majoring in the crafts. One noticable discrepancy, however, between major and planned occupation was that 14.8% were being trained in clerical practices compared to the 24.8% who planned to enter a clerical

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occupation. It is possible that disproportionate numbers of students majoring in such fields as business management, the liberal arts, or humanities were planning clerical rather than professional careers after graduation.

Occupational and educational aspirations. Deaf respondents were also requested to identify the occupation they aspired to three years after graduation. Sixty-nine percent named a job in three years that was the same as the job they planned immediately after graduation. These expectations convey a certain amount of reality. Across the spectrum of occupations there are many jobs which have limited prospects for upward career mobility. A mechanic or teacher, for example, may over time change employers or the place of work, yet would remain in the same occupation.

Obtaining more education or changing occupations, can lead to upward career mobility. While 69% of the deaf students planned to enter a white-collar occupation after graduation, 85% saw themselves in a white-job three years in the future. This difference of sixteen percentage points is most likely related to the proportion who will actually receive additional education in the future. Fifty-four percent of respondents in the classes of 1984 and 1985 stated they eventually wanted to get more education. However, only 33% stated that the first thing they planned to do after obtaining their current degree was to seek additional training. Given that not all of these respondents will actually obtain the financial support and other resources needed to obtain another degree, it is reasonable to presume that less than one-third will succeed in their educational aspirations. In support of this observation two studies of deaf alumni who graduated from NTID between 1969 and 1978 found that 11% were currently studying for an additional degree and that another 21% had completed courses towards another degree since their initial graduation from NTID (Grant & Welsh, 1981; Parker & Welsh, 1980). Considering that 83% of these NTID alumni had completed a two-year degree compared to 76% of respondents in the postsecondary classes of 1984 and 1985, the two groups are relatively comparable.

ALUMNI FOLLOW-UP SURVEY

Assessing the survey sample. The 371 hearing-impaired students in the class of 1984 who participated in the current student project composed the original target population for the alumni follow-up survey. Two factors, however, reduced the number of alumni eligible to participate in the survey: (1) 28 students declined to participate in the follow-up survey when their informed consent was requested in 1984, and (2) current addresses were not available for the 47 alumni who were not successfully located after three mailings of a tracing form. These conditions reduced the eligible survey population from 371 to 296 alumni who were successfully traced and who agreed to participate in the alumni survey. As shown in Table 11, 65.2% of these 296 alumni completed survey questionnaires. However, these respondents were not equally represented by type of postsecondary program in the obtained survey sample. Only 38% of traced alumni from the rehabilitation facilities completed survey questionnaires, compared to 58.6% of alumni from the technical institutes and 55.2% of alumni from the community colleges. In contrast, 80.4% of traced alumni from the four-year colleges responded to the mailed questionnaire. Likewise, 77.8% of traced alumni from federally

supported postsecondary programs completed the survey form compared to 52.3% of traced alumni from nonfederal programs. These response patterns resulted in an underrepresentation of alumni from the rehabilitation facilities, technical institutes, and community colleges and an overrepresentation of traced alumni from the four-year colleges in the obtained survey sample. Similarly, alumni from federal programs were overrepresented in the survey sample while alumni from nonfederal postsecondary programs were underrepresented. Consequently, in terms of the distribution of alumni respondents by the type of postsecondary program attended, the obtained survey sample was not completely representative of the target population for the study. This response bias in the alumni survey limits the generalizability of inferences which could be made from the results of the study.

TABLE 11

Percent Distributions of Alumni in the Class of 1984 Who Were Successfully Traced and Who Completed the Survey Questionnaire by Type of Postsecondary Program Attended

Type of Program	Successfully Traced		Completed Questionnaire		Percentage of Traced Alumni Completing Questionnaire
	N	%	N	%	
All Programs	296	100.0	193	100.0	65.2
Rehabilitation Facilities	42	14.2	16	8.3	38.0
Technical Institutes	58	19.6	34	17.6	58.6
Community Colleges	58	19.6	32	16.6	55.2
Four-Year Colleges	138	46.6	111	57.5	80.4
Federal Programs	149	50.3	116	60.1	77.8
Nonfedral Programs	147	49.7	77	39.9	52.3

It is also important to note that the alumni from the three rehabilitation facilities were included in this study only for descriptive purposes. Since there are 126 rehabilitation facilities serving hearing-impaired clients across the United States (Marut, Watson, & Buford, 1984), it was not intended that the three rehabilitation facilities in the deaf alumni survey represent this type of postsecondary training program.

Labor force participation. When contacted during the survey, 62.6% of alumni reported they were employed, while 14.2% were not employed, 20.5% were

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still in school, and 2.7% were not in the labor force (Table 12). The propor-
tion of alumni who were continuing their education varied by type of post-
secondary program attended. Less than 9% of deaf alumni from the technical
institutes were studying for any additional degree. Apparently, the type of
occupational training provided by the technical institutes is oriented towards
preparing students for direct entry into the labor force after graduation. In
comparison 43.7% of alumni from the rehabilitation facilities were continuing
their education. Many of these alumni received prevocational training at the
program they previously attended and thus were seeking additional education to
upgrade their skills before seeking employment.

TABLE 12

Percent Distribution of the Labor Force Status of the Class
of 1984 by Type of Postsecondary Program

| Type of Program | Labor Force Status[a] | | | | | |
	Total	Working	Not Working	Student	Not in Labor Force[b]	N
All Programs	100.0	62.6	14.2	20.5	2.7	190[c]
Rehabilitation Facilities	100.0	43.7	12.6	43.7	0.0	16
Technical Institutes	100.0	64.8	17.6	8.8	8.8	34
Community Colleges	100.0	43.3	16.7	36.7	3.3	30
Four-Year Colleges	100 0	70.0	12.7	16.4	.9	110
Federal Programs	100.0	70.2	13.2	14.9	1.7	114
Nonfederal Programs	100.0	51.3	15.8	28.9	4.0	76

[a] Labor force status determined at the time the alumnus responded to the
survey questionnaire. An additional 29 respondents had jobs after leaving
their program, but terminated employment for various reasons such as
returning to school for more education.

[b] Includes home makers and those not working for health reasons.

c Three unemployed respondents did not report their reason for not working.

Five of the 33 postsecondary programs in this study are largely supported by federal funds: Gallaudet, the National Technical Institute for the Deaf, California State University at Northridge, Seattle Community College, and St. Paul Technical-Vocational Institute. As presented in Table 12, 14.9% of alumni from these federal programs were continuing their education compared to 28.9% of alumni respondents from the nonfederal programs. A probable reason for this pattern is that most of the alumni from nonfederal programs were also from community colleges while most of the alumni from federal programs were also from programs classified as four-year colleges. As shown in Table 12, 37.6% of alumni from community colleges were still continuing their education compared to 16.4% of alumni from the four-year colleges. Other patterns in Table 12 regarding those who are either working or not working are better illustrated by the results provided in Table 13.

Employment status. As shown in Table 13, 81.5% of alumni respondents were employed while 18.5% were unemployed. Almost 28% of alumni from the community colleges were unemployed compared to 15% of alumni from four-year colleges. Differences in the educational attainments of alumni from these two types of programs are related to these patterns in unemployment. In the general labor force, those who are better educated are less likely to be unemployed compared to those with less education (U.S. Bureau of Labor Statistics, 1986). Differences in educational attainments also help explain why the unemployment rate for deaf alumni from the nonfederal programs is higher than the unemployment rate of alumni from the federal programs. It is known that 47% of deaf alumni respondents from the federal programs have obtained either a bachelor's or master's degree compared to 15.4% of deaf alumni from the nonfederal programs. Since those from the federal programs as a group have completed more education than have alumni from the nonfederal programs, it would be expected that the unemployment rate for the former would be lower than the unemployment rate for the latter.

This study found that 18.5% of deaf postsecondary alumni were unemployed. Comparatively, 6.8% of males and females in the general labor force with a similar range in age and educational attainments were also unemployed (U.S. Bureau of Labor Statistics, 1986). Several factors account for this higher rate of unemployment among the college-educated deaf alumni over their counterparts who hear. One is that the data collection period was much longer in time for this follow-up survey of the deaf alumni than that used by the federal government in their surveys of the general labor market. This difference in time increases the probability that proportionately more deaf than hearing respondents will be out of work. The typical deaf job seeker in this study found his or her current occupation after eight to nine weeks of looking for employment. Another reason for the larger percentage of those without a job is related to the observation that most of the deaf respondents recently graduated from their postsecondary program. In support of this interpretation Welsh (1986) found in a study of deaf alumni from NTID that the rate of unemployment decreased as the period of time since graduation increased: 13.7% of those who graduated in 1984 or 1985 were unemployed compared to the 8.1% unemployed among alumni in the classes of 1981 to 1983, 3.9% unemployed among alumni in the classes of 1975 to 1980, and 2.1% unemployed among alumni who graduated from NTID before 1975. However, evidence from other studies

TABLE 13

Percent Distribution of Employment Status of Class of 1984 by Type of Postsecondary Program

| | | Employment Status[a] | | |
	Total	Working	Not Working	N
All Programs	100.0	81.5	18.5	146
Rehabilitation Facilities	100.0	77.8[b]	22.2[b]	9[b]
Technical Institutes	100.0	78.6	21.4	28
Community Colleges	100.0	72.2	27.8	18
Four-Year Colleges	100.0	84.6	15.4	91
Federal Programs	100.0	83.3	16.7	95
Nonfederal Programs	100.0	76.4	23.6	46

[a] Includes only those in the labor market as defined by U.S. Bureau of Labor Statistics (1986).

[b] Percentages probably unreliable due to small N.

Indicates that a high level of unemployment among deaf college alumni has persisted for some time. During the early 1980's when 2.8% of college graduates who hear were out of work, 7% of Gallaudet and NTID graduates were unemployed (Armstrong, 1981; Barden, 1982; MacLeod & Welsh, 1982). More recently, while 3% of Gallaudet male graduates and male college graduates who hear were unemployed, 5% of Gallaudet female graduates were out of work, compared to 3% of their counterparts who hear (Rawlings, Karchmer, King, & Brown, 1985). In conclusion, one interpretation of all these patterns is that the overall rate of unemployment among deaf alumni in the postsecondary class of 1984 would be twice as large rather than three times larger than the rate of joblessness for their counterparts who hear.

Occupational attainments. Deaf alumni in the class of 1984 were working in a wide range of occupations. The 148 employed individuals in this class were found in 75 different specific occupations. Forty percent, however, were working in seven occupations: as teachers, counselors, teacher's aides, computer programmers, computer operators, general office clerks, or postal service clerks. The distribution of the occupational categories for these employed alumni are shown in Table 14. Thirty percent were working in professional or technical jobs and 28% are in clerical occupations. There were also concentrations of respondents in the crafts and service occupations.

While there is clustering in the occupations held by survey respondents, it is important to recognize the diversity of jobs in which these deaf alumni were employed. This occupational diversity reflects the fact that the class of 1984 in a heterogeneous group of individuals who were educated in a broad variety of majors at a large number of special postsecondary programs across the United States.

TABLE 14

Percent Distribution of Present Occupation, Class of 1984

Occupational Group	Present Occupation
Professional and Technical	30.4
Managerial	6.1
Sales Workers	.7
Clerical Workers	28.4
Craftsmen	12.8
Machine and Transit Operatives	4.8
Farmers & Laborers[a]	0.0
Service Workers	15.5
Private Household Workers	0.0
Total	100.0
N	148

a Includes farm and nonfarm laborers.

Alumni attitudes. Deaf alumni in the class of 1984 were asked to express both their likes and dislikes about their postsecondary training program. Their responses to these questions indicated that the training alumni received in their major was the most frequently reported source of both positive and negative attitudes about their postsecondary program. Alumni were also asked what additional work skills they wished their postsecondary program had provided. Work skills related to the major rather than other aspects of the respondent's job (e.g., career development skills, work interpersonal skills) were the most often reported type of response to this question. Evidently, the major or area of vocational training is a central focal point of the attitudes of these deaf alumni towards their postsecondary program.

CONCLUSIONS

It is appropriate that the deaf students in the classes of 1984 and 1985 received their postsecondary education from special programs which offered support services provided by trained staff. Eighty-four percent of these students became deaf prior to age four and 12% had additional disabilities besides deafness. These students as a group were more likely to evaluate their manual communication skills better than their oral communication abilities. The deaf graduates in the classes of 1984 and 1985 originated from 47 states and attended postsecondary programs located in 23 states. When the distribution of respondents' native states was compared to the states where respondents received their postsecondary training, several regional patterns were identified. Thirty percent of the programs and 30% of the deaf students were clustered in the North Central region. In 3 of the 10 regions the number of deaf students receiving postsecondary training exceeded the number of respondents who graduated from a high school within the region. Each of these three regions also had a federally supported postsecondary program. Deaf respondents received more encouragement to attend college from their parents, rather than from high school staff, rehabilitation counselors, friends, or other persons. College-educated parents provided more encouragement than did parents without a college education. College-educated parents also were more likely to encourage their deaf offspring to attend an academic rather than a nonacademic postsecondary program. Parental encouragement to attend college reflects not only the parents' own aspirations for their deaf son or daughter, but also the abilities of their deaf offspring. Deaf students from academic programs were found to rate their oral and manual communicative skills better than did deaf students from the rehabilitation-technical program.

Deaf students were conscious of the fact that employment after graduation is an important goal of their postsecondary education. The capacity of a postsecondary program to provide a good education or good vocational training were the leading reasons why deaf students selected their program. Fifty-eight percent of the deaf respondents named a job-related reason for selecting their major. Two-thirds of the students majored in fields expected to lead to white-collar employment after graduation; the other third received training in fields related to blue-collar employment. The occupational plans of most deaf respondents were also found to be closely related to their majors: 69% of the deaf respondents planned to enter a white-collar occupation after graduation and 66% were majoring in a white-collar field.

Additionally, this study determined that 42% of the deaf students in the classes of 1984 and 1985 planned to enter a professional or technical occupation after their graduation. None, however, planned to enter such high-level professions as law, medicine, dentistry, banking, or architecture. Few were majoring in the sciences or engineering. The underrepresentation of deaf persons in these high-status professions consequently was expected to persist. One-third of these deaf students aspired to obtain an additional degree. However, only 20% of alumni respondents actually did so.

It is important to note that 76% of the students in the classes of 1984 and 1985 expected to graduate with either a vocational degree or an associates

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degree. Comparatively, 29% of college degrees awarded to the general popula-
tion in 1980 were two-year degrees. Several factors relate to this under-
representation of deaf persons earning higher degrees. Most deaf students
aspired to enter occupations which require two years rather than four years of
postsecondary training. Additionally, deaf students require more time than
their counterparts who hear in completing their education.

A follow-up study of the class of 1984 found that 81% were employed 18
months after graduation. Differences were also found in the proportions of
deaf alumni from the different types of postsecondary programs who were
unemployed. Differences in the educational attainments of the deaf alumni
were related to these patterns in unemployment. Overall, the proportion of
deaf college alumni who were out of work was three times higher than for their
counterparts in the general labor force. The follow-up survey also found
variations in the proportions of deaf alumni from the different types of
programs who were continuing their education. Proportionally fewer deaf
alumni from the technical institutes were studying to obtain a higher degree.
Deaf alumni were employed in a wide variety of occupations. Concentrations
were working in professional, technical, or clerical jobs. Some clustering
was also found among those employed in the crafts and service occupations.

Selecting a major is perhaps the most important decision a student makes
while acquiring a postsecondary education. Attitudes of deaf alumni towards
their postsecondary program focused upon the training they received in their
major. This study also found relationships between a student's major or type
of training and his or her educational and occupational plans and aspirations.
There is also evidence that the type of job a graduate receives is related to
the type of major that student was trained in. Since the 1970's there has
been dramatic decreases in the proportion of college students majoring in the
liberal arts and humanities with corresponding increases in the percentages of
students majoring in vocationally relevant fields (Astin, 1985; Roemer, 1985).
Students are thus motivated to obtain postsecondary training to enhance their
prospects for employment and economic self-sufficiency. A student's commit-
ment to a vocational goal as well as his or her educational aspirations were
significant predictors of persistence in completing a college education (Beal
& Noel, 1980; Cope & Hannah, 1975; Fullerton & Britton, 1976; Munro, 1981).

Given the importance of the postsecondary major, there is evidence that
deaf students entering postsecondary schooling are frequently unprepared to
select this major. Many of these students leave high school unexperienced
with the work world and unaware of career options (Chubon & Black, 1985;
Lerman & Guilfoyle, 1970). Studies at NTID have reported that almost 50% of
entering deaf students and 36% of all NTID students changed their majors
(DiLorenzo & Welsh, 1981b; McKee, Whitehead, & Bondi-Wolcott, 1984). The high
frequency in which deaf postsecondary students change their majors increases
their time in training. This is expensive to both the postsecondary program
as well as to vocational rehabilitation agencies who fund this training. The
solution to this problem will require increased career education during high
school and improved vocational evaluation and career counseling after high
school. An additional benefit of these professional interventions probably
will be a reduction in the percentage of deaf postsecondary alumni who are
unemployed.

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Cooperating Postsecondary Programs

Rehabilitation Facilities

Alabama Institute for the Deaf
La Puente Valley Adult School (CA)
Northern Illinois University, Rehabilitation Facility

Technical Institutes

Columbus Technical Institute (OH)
Milwaukee Area Technical College (WI)
North Central Technical Institute (WI)
St. Paul Technical-Vocational Institute (MN)
Tampa Technical Institute (FL)
Texas State Technical Institute
West Valley Occupational Center (CA)

Community Colleges

Central Piedmont Community College (NC)
Chattanooga State Technical College (TN)
Floyd Junior College (GA)
Front Range Community College (CO)
Golden West College (CA)
Iowa Western Community College
Johnson County Community College (KS)
Los Angeles Pierce College (CA)
Mott Community College (MI)
Mount Aloysius Junior College (PA)
New River Community College (VA)
Northwestern Connecticut Community College (CN)
Ohlone College (CA)
Pasadena City College (CA)
Portland Community College (OR)
San Jose Community College (CA)
Seattle Community College (WN)
Southwest Collegiate Institute for the Deaf (TX)
St. Louis Community College, Florissant Valley (MO)
Waubonsee Community College (IL)
Western Piedmont Community College (NC)
W.R. Harper College (IL)

Four-Year Colleges

California State University at Northridge
East Central Oklahoma State University
Gallaudet College (DC)
Madonna College (MI)
Michigan State University
National Technical Institute for the Deaf (NY)
New York University
Northern Illinois University
Western Oregon State College

TRANSITION FROM SCHOOL TO WORK: EMPLOYERS' PERCEPTIONS OF HEARING-IMPAIRED GRADUATES OF POSTSECONDARY PROGRAMS

AFAFE EL-KHIAMI

This paper reports employers' evaluation of the work performance of hearing-impaired alumni of 21 different postsecondary programs. Employers' perceptions as to the adequacy of the hearing-impaired graduates preparation for the technical as well as the non-technical aspects of the world of work are discussed. Additionally, the attitudes and obstacles they see as hindering hearing-impaired individuals' active participation in the labor force are presented. The reported data and its interpretation should take into consideration the characteristics of the sample of employers, the nature of the jobs the hearing-impaired employees hold, and the type of postsecondary programs these latters graduated from.

In addition to its intrinsic value, one of the main objectives of education is to prepare the individual for the adult role. As working is a centr l activity in adult life; employment becomes an important aspect of this r le (Roe, 1956; Hall, 1975). Researchers in the field of work and occupations agree that beyond their technical and economic characteristics, jobs can also be defined in terms of identifiable social roles, that is, a whole host of social activities and interactions which have meanings to all participants (Salz, 1955; Hughes, 1965; Parker & Smith, 1976; Fox & Hesse-Biber, 1984; Hall, 1986).

This comprehensive definition emphasizes that employment goes beyond fulfilling the financial needs of the individual. It provides a potential source of identity and social status (Salz, 1944; Hall, 1986). For disabled persons, the social aspects of work are as important, if not more important than the economic aspects. In the field of rehabilitation, active participation in the labor force is recommended as the way to integrate disabled

Individuals Into the mainstream of society. In addition to promoting finar-
cial Independence and enhancing feelings of self-worth, employment provides
opportunities for social interaction (Brolin, 1976). As Wehman points out,
Its advantages go beyond wages and benefits to encompass Intangibles such as
emulation, incidental learning and mutual adjustment on the part of both
handicapped and non-handicapped individuals. Moreover, the visibility
accruing from the disabled person's entry into the labor market acts as the
best advocate to improve the perceptions of employers and legislators alike
(Wehman, 1981).

This paper reports employers' evaluation of the work performance of
hearing-impaired alumni of 21 different postsecondary programs. Employers'
perceptions as to the adequacy of the hearing-impaired graduates preparation
for the technical as well as the non-technical aspects of the world of work
are discussed. In addition, the attitudes and obstacles they see as hindering
hearing-impaired individuals' active participation in the labor force are
reviewed. As former and current employers of deaf persons, they are in a
unique position to provide useful insights based on their personal experiences
to improve the vocational outlook of hearing-impaired graduates. Their
suggestions and recommendations are to be heeded by educators, counselors, job
placement specialists, and all those interested in promoting the employment of
deaf persons. The information is reported across all programs and is
discussed by types of programs whenever a significant difference has been
detected.

Though more difficult than surveying job holders, polling employers and
learning about their attitudes and perceptions is of vital importance for a
realistic evaluation of the vocational future of hearing-impaired individuals.
Until recently, studies pertaining to the employment of deaf individuals
relied almost exclusively on their self-reports. Employers have seldom been
polled and for very good reasons as we have learned.

The results reported in this paper are part of a comprehensive study of 46
postsecondary programs for hearing-impaired individuals. The evaluation of
these programs includes the views of the students during their senior year and
a year later as alumni, the perceptions of their parents, vocational rehabili-
tation counselors, and finally their employers. Employers stand in a dif-
ferent kind of relationship to the hearing-impaired alumni than their parents
or their vocational rehabilitation counselors. As a consequence, the privacy
act proved to be an unsurmountable obstacle for obtaining employee-specific
information. Consent is needed from both the employer and the employee to get
any information on the latter. It is understandable that evaluation of work
performance, skills, and behavior in the workplace may be perceived as
threatening to the individual, and more so to the disabled person. Therefore,
few alumni were expected to provide the name of their employers or consent to
our contacting them. Even with a consent form from employees, fear of liti-
gation would have significantly reduced employers' responses.

In view of these difficulties, the original research design that called
for the identification and survey of employers of the class of 1984 graduates
was abandoned. It was replaced by a new research plan which surveyed
employers' perceptions about the job performance of hearing-impaired employees

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who are graduates of specific postsecondary programs. The challenge was to find sources of information on a national sample of employers of hearing-impaired graduates from the postsecondary programs included in our survey. Two such sources were identified. First, we asked the schools' program coordinators in their questionnaire to provide us with the names and addresses of up to ten employers of their recent graduates. Needless to say, few schools had such information. Second, we asked the same information from the students' VR counselors. Most of them did give us names of employers while some were very fearful and protective of their job leads and .efused to do so. In sum, despite our efforts, the sample of employers of hearing-impaired graduates of the 46 postsecondary programs, though national in scope, can be characterized, at best, as a convenience sample. Two mailings of 243 usable addresses of employers, netted 123 completed forms i.e., a response rate of 50.6%. Who are these employers? Which sector of the economy are they from? What industry do they represent? Which type of postsecondary programs are their hearing-impaired employees from? Have they had any interaction with hearing-impaired individuals prior to hiring one? These are some of the questi-ns which put in proper perspective the information the surveyed employe.s provided and also give a more complete picture of the scope of the current job market open to hearing-impaired persons.

SURVEY SAMPLE CHARACTERISTICS

All ten RSA regions are represented in the employers survey. Employers from Region VII constitute the highest percentage (22%) of respondents in the sample, followed by employers from Region V (20%). Respondents from Region I accounted for 1;% of the sample. Region III and Region IV are equally represented by 10% each, Region IX and Region X by 7% each, and finally Region II and Region VI by 6% each. Employers from Region VIII are the least represented in the survey sample (1%). Almost one-half (44.3%) of the employers answering this survey had no interaction with a hearing-impaired person prior to hiring one. From their experiences with program graduates, 48% of the employers in the sample report on four-year colleges, 28.5% on rehabilitation-vocational/technical programs (rehab-votec), and the remaining 23.5% on two-year colleges (Figure 1a). This overrepresentation of employers of four-year hearing-impaired college graduates compared to alumni of the other two types of postsecondary programs is to be noted.

While the duration of the hearing-impaired worker's employment tenure ranges from less than one year to forty years, the modal length of tenure of these program g.'aduates is two years. This means that several of the employers (41%) are likely to be evaluating recent postsecondary graduates (about whom information is collected in other parts of the study).

In this sample, employers whose organization deal with the hearing oublic constitute the majority, 77.2% (Figure 1b). Furthermore, almost one-half of the employers surveyed (48.8%) are private businesses, one-third (33.3%) are government agencies, and 17.9% are from educational institutions (Figure 1c). Industrial sectors are differentially represented in this survey. Due to the composition of the employers' sample--which include a disproportionate number of employers of hearing-impaired four-year college graduates--the professional

services sector boasts the highest representation (40.7%), followed by manu-
facturing (18.7%), transport (11.4%), finance (8.1%), public administration
(7.3%), trade and business services, each (5.7%), agriculture, mining, and
construction (1.6%) and personal services (0.8%), as indicated in Figure 1d.
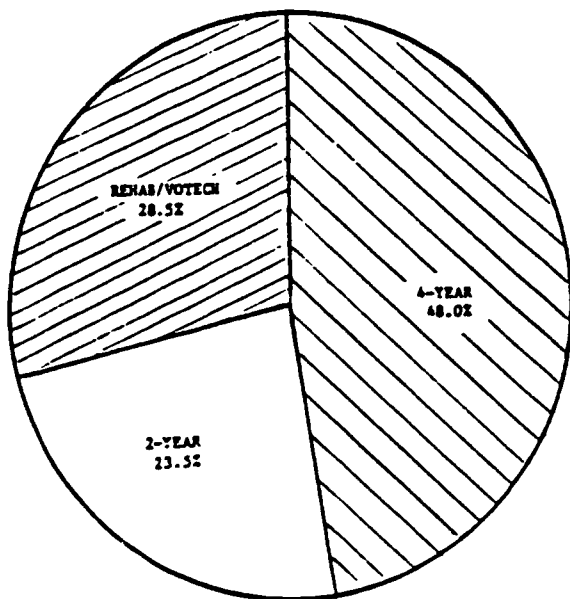
Fig. 1a
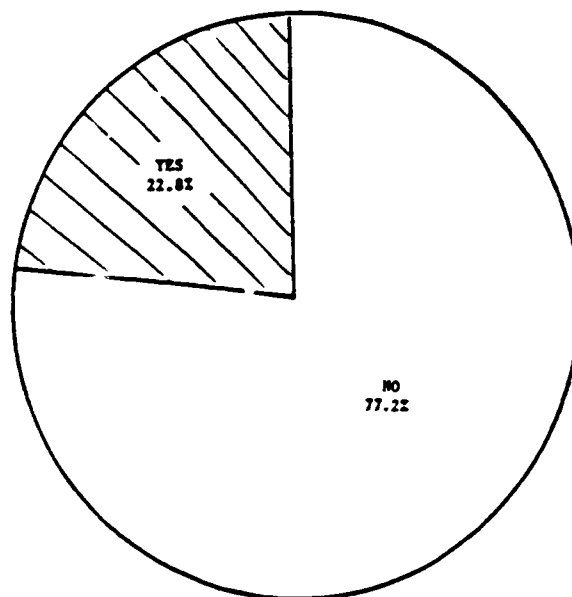
Fig. 1b
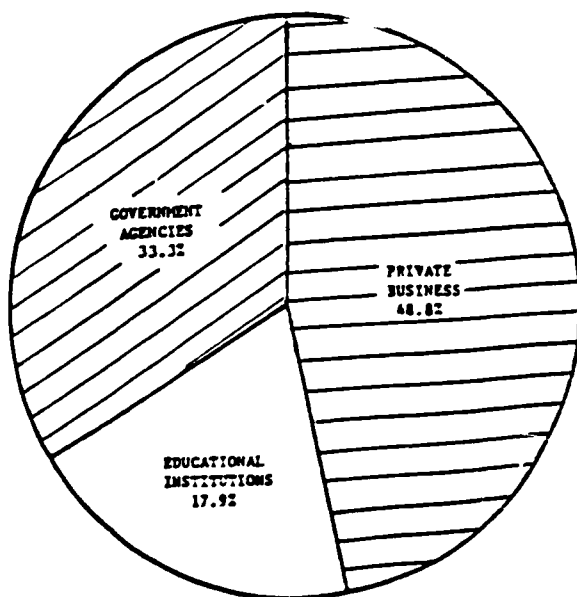
Fig. 1c
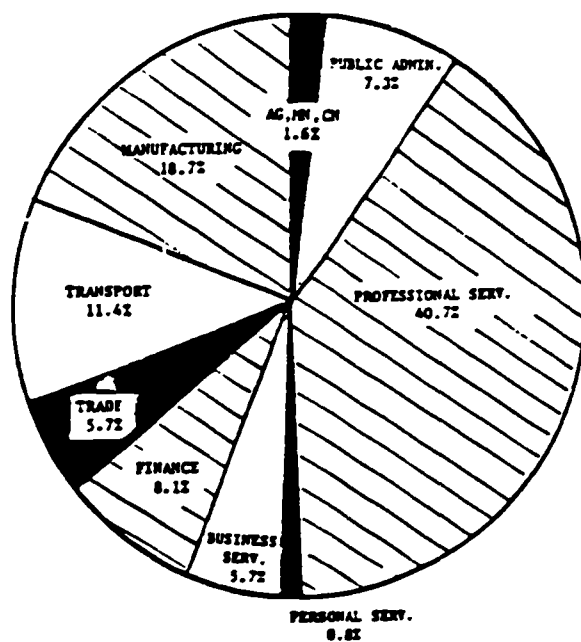
Fig. 1d

JOBS HELD BY POSTSECONDARY GRADUATES

Two occupational classifications are used here to describe jobs held by postsecondary graduates in these industrial sectors. (1) The white/blue/farm classification: The majority of the employers surveyed (80.4%) indicate that the hearing-impaired graduates they have hired are in white-collar jobs and 19.6% in blue-collar jobs (Figure 2a). In this context, it is worth noting that a negligible percentage (1%) of hearing-impaired individuals work in farming (El-Khlami, 1986). Furthermore, it is reasonable to assume that these people are either self or family employed and as such will not be included in the employers sample. (2) The Census classification: More detailed information about the occupations of the hearing-impaired postsecondary graduates is provided by the Census classification system. A sizable percentage of the employers (39.5%) reported hiring hearing-impaired persons in professional-technical jobs. One-third mentioned them working as clerical staff in their organizations or businesses. However, Figure 2b indicates that fewer employers stated hearing-impaired graduates of postsecondary programs as having jobs in service occupations (6.5%), as operatives (5.8%), managers (5.8%), craftsmen (6.3%), transport (1.1%), household and sales (1.1%).
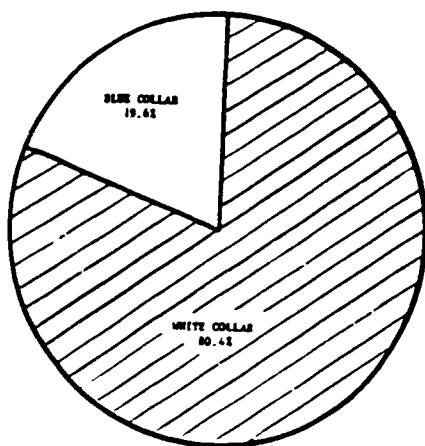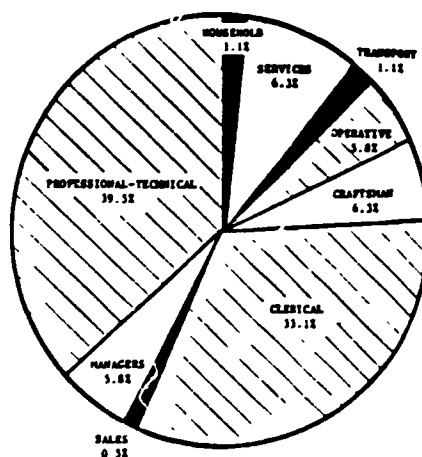
Fig. 2a   Fig. 2b

EFFECT OF TYPE OF PROGRAM ON OCCUPATION

In this section, the duration of the employer's practice of hiring hearing-impaired graduates from selected postsecondary programs is examined in general and by type of program. Across all program types, one quarter of the employers surveyed (25.7%) had a relatively long standing practice, eight years or more, of employing hearing-impaired individuals from the identified programs. The majority of these employers (60.7%) reported hiring hearing-impaired four-year college graduates. Employers comprising this group are mostly educational institutions or agencies serving deaf persons. In these settings, the employment of qualified hearing-impaired individuals presents definite advantages in terms of communication, valuable insights afforded by personal experience, and the provision of role models. The percentage of employers who began to hire graduates from the identified postsecondary

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programs in the past three to seven years is 36.7%; while employers who began
to employ program graduates only one to two years ago account for 37.6% of the
sample. These results indicate a trend not previously documented that more
and more employers are hiring hearing-impaired individuals.

When examined by type of postsecondary program, there is a statistically
significant difference (p = 0.0154) in the percentages of employers (reporting
on the length of time they have been) hiring graduates from the three types of
postsecondary programs. Data in Table 1 indicate that of the three types of
postsecondary programs, more than half (58.1%) of the employers of rehab-votec
graduates report it as a recent experience of one to two years. This trans-
lates to a trend in widening of the job market for hearing-impaired alumni of
this type of program. By the same token, the similarity in percentages
(42.3%) reporting employing hearing-impaired graduates of two-year colleges,
from one to two years and from three to seven years, may be construed as a
possible stabilization in demand for these type of graduates. Employers of
four-year college alumni are disproportionately 'stributed in the three cate-
gories of recruitment; the largest percentage (44.2%) report having hired
hearing-impaired individuals from these colleges the past 3 to 7 years. The
smallest percentage (23.1%) report it as a fairly recent experience of one to
two years. Therefore, the reported increase in the overall proportion of sur-
veyed employers recently hiring hearing-impaired postsecondary graduates
across all programs pointed out at the beginning of this section is indicative
of an improved occupational outlook. Contrary to the prevailing notion, the
relative increase in placement rates in the past few years has not been
achieved by four-year college graduates, but rather by rehab-votec and two-
year college alumni. Furthermore, of the 37.6% employers reporting hiring
hearing-impaired employees from all these programs in the past year or two,
43.9% mentioned that the newly employed are rehab-votec graduates.

The increase in vocational opportunities available to students of rehab-
votec types of programs is due to concerted, three-pronged efforts. First,
the continued and sustained placement activities of vocational rehabilitation
counselors. Second, the rise and expansion of advocacy groups and their
efforts toward heightening the awareness of employers and the community at
large about the vocational potential of hearing-impaired individuals. Third,
the active participation of an increasing number of postsecondary programs in
the placement of their graduates. In fact, while it comes as no surprise that
65.8% of surveyed employers of four-year college alumni were contacted by the
programs to promote the hiring of their graduates, almost one-half (45.8%) of
the employers of rehab-votec alumni reported a similar experience. It appears
that a number of postsecondary programs decided to join forces with vocational
rehabilitation and consider placement as part of their mission (Table 1).
From the results presented above, one can safely assume that these concerted
efforts have already started to affect the occupational outlook for hearing-
impaired individuals in terms of quantity, quality and diversity of job oppor-
tunities.

Results reported in Table 1 indicate that employers from the private busi-
ness sector constitute consistently the highest proportion of employers, com-
pared to educational institutions or government agencies, across all program
types. However, this distribution differs significantly within each type of

TABLE 1

Employers Reported Variables Which Differ Significantly By Hearing-Impaired Employee Type of Postsecondary Programs

Employers Reported Variables	Re-Votec		2-Year		4-Year	
	N	%	N	%	N	%
Recruitment Duration						
Total	31	28.4	26	23.9	52	47.7
Low	18	58.1	11	42.3	12	23.1
Medium	6	19.4	11	42.3	23	44.2
High	7	22.6	4	15.4	17	32.7
Chi Square = 12.272 d.f. = 4 p = 0.0154						
Program Placement Efforts						
Total	24	31.2	15	19.5	38	49.3
Yes	11	45.8	4	26.7	25	65.8
No	13	54.2	11	73.3	13	34.2
Chi Square = 7.117 d.f. = 2 p = 0.0285						
Type of Employment						
Total	35	28.5	29	23.5	59	48.0
Gov. Agency	10	28.6	11	37.9	20	33.9
Educational Inst.	0	0.0	5	17.2	17	28.8
Private Business	25	71.4	13	44.8	22	37.3
Chi Square = 16.004 d.f. = 4 p = 0.0003						
On the Job Interaction With Hearing-Impaired Individuals						
Total	35	28.5	29	23.5	59	48.0
Yes	1	2.9	5	17.2	22	37.3
No	34	97.1	24	82.8	37	62.7
Chi Square = 15.47051 d.f. = 2 p = 0.0004						

program (p = 0.0003). In this sample, the variability in the percentages of type of employers of four-year college graduates is relatively limited compared to that of two-year college and rehab-votec alumni. For example, among employers of this later type of postsecondary program graduates, 71.4% are from the private business sector and the remainder 28.6% from government agencies. Among the surveyed employers of two-year college graduates, 44.8% are from the private business sector, 17.2% from educational institutions and 37.9% from the government sector. The distribution of the sampled employers of four-year college graduates exhibit, as previously noted, a limited variability when classified by employment sector. While 37.3% of them are from private business, 33.9% are from the government sector, and 28.8% from educational institution.

The patterns discussed above point to the importance of the private sector as a potential employer of hearing-impaired graduates from all types of postsecondary programs. This is particularly true of alumni of rehab and vo-tec programs who may be considered more difficult to place. This is due to the nature of the jobs they qualify for. Generally, these jobs do not require a relatively high educational level and therefore more people meet these requirements and compete to get them.

In addition, the sampled employers were classified into two groups--those whose organizations or businesses serve hearing-impaired individuals and those who do not. Their distribution--by their employees type of postsecondary p.ogram--was examined; Table 1 indicates that it varies significantly in the three types of programs (p = 0.0004). Interacting with hearing-impaired individuals as part of the job is reported most often (37.3%) by employers of four-year college deaf graduates, followed by employers of two-year college alumni (17.2%) and by only 2.9% of employers of rehab-votec graduates. These results further document the employers' emphasis on hiring graduates with the required job skills and abilities rather than discriminating aga.nst the special characteristics resulting from their impaired hearing.

EMPLOYERS' EVALUATION

There has been some concerns expressed in the literature, though seldom backed by data, about safety, absenteeism and, in general, the overall performance of hearing-impaired employees. In order to seperate myths or stereotypes from reality, the employers were surveyed as to their opinions about the technical and nontechnical aspects of hearing-impaired persons preparedness in the work setting.

Safety is a valid concern particularly in blue-collar jobs; however, only one-fifth of the surveyed employers reported having concerns in this category. Keeping this in mind, employers' evaluation of the safety record of their hearing-impaired employees is overwhelmingly positive (Figure 3a). Also, of special significance to employers is the issue of absenteeism. Whether in blue or white-collar occupations, the interdependence of tasks at the workplace are aggravated by disruptions that are created by the unplanned absence of an employee. Furthermore, income maintenance programs targeted to help disabled individuals may affect the latters' incentives to work or to retain a job once they obtain one. Whether these effects are real or imaginary, the

availability of an alternative source of income other than earnings, serve to perpetuate, at least in the minds of employers, a stereotype of the disabled worker as unreliable. However, the majority of the employers surveyed (64.2%) rate hearing-impaired employees records on absenteeism as excellent or above average compared to others, while 30% report it as average, only 5% characterize it as below average, and a negligible 0.8% view it as poor (Figure 3b).

How do hearing-impaired employees fare on overall performance? Almost equal percentages of employers rated them as above average and average (40% and 41.7%, respectively) and only 1.7% were not satisfied with the overall performance of their hearing-impaired employees (Figure 3c). Data indicate that employers seem to be satisfied with the technical preparation of the postsecondary graduates. One quarter of the sample (25.6%) stated that these graduates possessed all the necessary skills prior to hiring; 13.2% reported that simple demonstrations were all that was necessary to get them started; 30.6% of the employers gave them on-the-job training for less than a month; 28.1% offered specialized training for a month or more; and 2.5% of the employers mentioned that it took a combination of at least two of the above. It should be noted that there was no statistically significant difference in employers' evaluation of the technical preparation of postsecondary graduates by type of programs. In other words, the technical preparation provided by different postsecondary programs to their hearing-impaired alumni was rated as adequate, irrespective of the type of program they graduated from. This is also documented in the employers' ratings of their hearing-impaired employees' possession of the skills required for satisfactory performance of their jobs. The majority of employers (80.3%) evaluated the graduates' job skills as good or very good, 18.8% as fair, and less than 1% (0.9%) as poor.

The employers were also asked to rate their hearing-impaired employees' social behavior at the workplace, such as getting along with co-workers and supervisors. Data reported in Table 2 indicate that deaf workers manage equally well in their social interaction with colleagues and with supervisors as 92.5% of the employers rated social interaction skills as very good or good. The remaining 7.5% rated it as fair. The employers' evaluation of their hearing-impaired employees' ability to follow instructions is also overwhelmingly positive as 88.4% rated it as very good or good, 10.8% as fair, and less than 1% (0.8%) as poor. It is reasonable to assume that individuals with limited ability to follow instructions will also rate poorly on adaptability to changes in procedures and methods. The data bear out this fact as a similar percentage (0.8%) of employers characterize their hearing-impaired employees' flexibility as poor. One-quarter of the sample rates it as fair, 48.3% as good and 25.9% as very good. None of the employers thought of the quantity or quality of work of the postsecondary graduates they have hired as poor (Table 2). Very few employers (0.8%) evaluated the punctuality of deaf persons on their payroll as poor and only 1.7% of them similiarly rated their initiative. The item employers rated as poor more than any other is the chances for advancement of their hearing-impaired employees. However, as these employers constitute only 5.7% of the sample compared to one-quarter (25.4%) who rate it as fair, 69.2% as good and 19.7% as very good, the likelihood of a positive occupational outlook for hearing-impaired postsecondary graduates seems to be substantial.
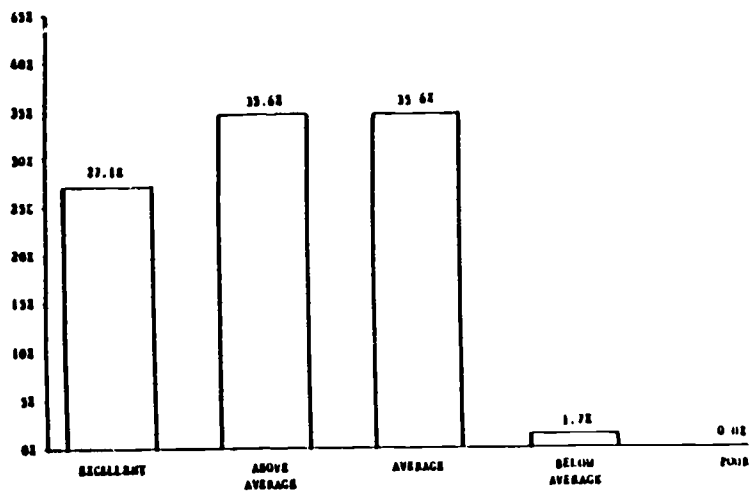
Fig. 3a - Safety Record
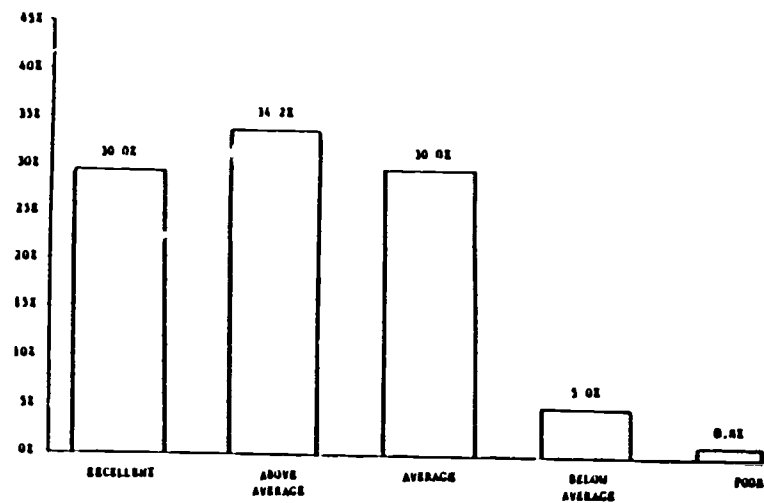
Fig. 3b - Absenteeism
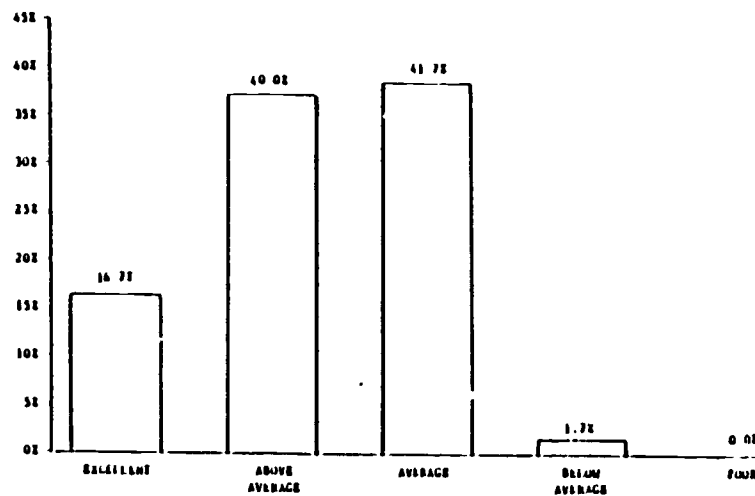
Fig. 3c - Overall Performance

TABLE 2

Employers Evaluation of Hearing-Impaired Employees, Graduates of Postsecondary Programs

Items	Rating			
	Very Good %	Good %	Fair %	Poor %
a. Possession of special knowledge and skills required for the job	31.6	48.7	18.8	0.9
b. Ability to get along with co-workers	49.2	43.3	7.5	0.0
c. Ability to get along with supervisors	48.3	44.2	7.5	0.0
d. Ability to follow instructions	35.1	53.3	10.8	0.8
e. Adaptation to changes in procedures and methods	25.9	48.3	25.0	0.8
f. Quality of work	35.8	58.4	5.8	0.0
g. Quantity of work	42.9	42.9	14.2	0.0
h. Punctuality	49.2	45.8	4.2	0.8
i. Initiative (self-starter)	36.4	69.2	12.7	1.7
j. Chances for advancement	19.7	69.2	25.4	5.7

Limitations due to type of job or the size of the company are the reasons given by the 5.7% who rated the opportunities for advancement of their deaf employees as poor. Although the need for communication may slightly affect chances of promotions, employers have been willing to restructure jobs and/or modify them to accommodate hearing-impaired employees. When asked if "they would hire other hearing-impaired graduates from the same postsecondary program," the overwhelming majority of the employers surveyed (96.6%) answered affirmatively.

EMPLOYERS' PERCEPTIONS

Because the ultimate pragmatic test of a good education is employment, the sampled employers were polled on a number of issues. The first of these is "what could postsecondary programs do to better train their graduates for participating in the labor force?" Though 17% of the employers answered that they were satisfied with the job done by postsecondary programs, 32% mentioned better preparation for the nontechnical aspect of the work world. One-fifth (20%) of the employers reported the need for more "hands-on-experience."

When asked about the barriers to hiring hearing-impaired individuals, communication was the reason given most often. For example, one-fourth of the employers in the sample mentioned the communication prerequisite in most jobs. Though phone communication is dealt with by restructuring or modifying jobs, the purchase of special equipment, e.g., TDDs, does not always resolve the problem as these devices are necessary for both communicating parties. But, with the spreading of the ownership of personal computers and the development of appropriate software, these can be used as communication devices. However, what is meant in this context is direct communication with the public. Given that the fastest growing sector of the economy is the service sector; predictions are that it is in this sector that available jobs will be located. But, most of these jobs require interaction with the public.

Not all of the employers consider communication as an unsurmountable barrier. Almost a fifth (18.1%) argue that the real barrier is the stereotype related to the difficulty in communication with hearing-impaired individuals. An almost equal percentage (20.7%) report that speed and accuracy of communication, especially with co-workers, can be vital in some occupations. Only very few of the employers surveyed, less than 5% (4.3%), mentioned the need to use sign language interpreters as a barrier. As to the incentives for hiring applicants from this disability group, personal quality was mentioned most often by the employers (41.2%). One-fifth of the employers in the sample reported enforcing affirmative action as a good incentive, particularly since hiring members of this disability group often requires minimal job modification.

When asked what they think needs to be done to promote the hiring of hearing-impaired persons--about 70% of the employers reported the need to educate the public and other employers. Other suggestions were: advertise success stories, have a list of references of satisfied employers willing to share their experiences in hiring hearing-impaired individuals, availability of VR to help when needed, more preparation of the hearing-impaired person to deal with the world of work, dispel the myth that communication is impossible without the knowledge of sign language.

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CONCLUSION

In interpreting and using these results, two important caveats need to be made. T e first is that the employers surveyed are reporting on their experiences in hiring postsecondary graduates, a large proportion of whom are four-year college graduates i.e., high functioning hearing-impaired individuals. The second is that the employers who have been contacted and responded do not constitute a random sample. Furthermore, we do not have information on the total population of employers who have hearing-impaired employees on their payroll to find out if the sample in this study is a representative one. Given the lack of such a data base and the restrictions imposed by the privacy act, findings from employers surveys will be at best indicative of patterns and trends. They cannot be generalized beyond the scope of the sample frcm which they were obtained.

What can be said from the sample of employers this study surveyed is that the experiences they had in hiring hearing-impaired postsecondary graduates are overwhelmingly positive across all types of postsecondary program graduates. In other words, these educational programs are effectively preparing deaf individuals for employment. The responses received from the employers indicated the adequacy of the technical preparation provided by the programs, but, their answers also indicate that more could be done to improve the graduates' coping with the non-technical aspects of the world of work. This, by no means, implies problematic social relationships as hearing-impaired employees were positively rated on their ability to get along with co-workers and supervisors alike.

Four variables differed significantly ($p < 0.05$) by type of postsecondary program. The first is the length of time employers in the sample have been involved in recruiting hearing-impaired students from postsecondary programs. Higher percentages of employers report hiring hearing-impaired alumni from the various types of programs as a relatively recent experience. This may be construed as a sign of a more favorable job market for deaf graduates. When the increase in hiring is examined by type of program, results indicate that in this sample, employers have recently recruited a higher proportion of hearing-impaired employees from rehab-votec programs; more than from any other type of postsecondary program. These findings document the effectiveness of placement efforts by vocational rehabilitation counselors and the schools. In fact, rehab-votec programs appear to be very actively involved in the placement of their graduates. Data in Table 1 show that 45.8% of the employers who employ graduates of rehab-votec programs have been contacted by these programs to promote the hiring of their students. Therefore, the onus of finding jobs for hearing-impaired individuals with limited skills and education is no longer totally left to the vocational rehabilitation counselor but is shared by the postsecondary training programs.

Though this sample of employers is not random and its representativeness cannot be assessed, it s uld be noted that the highest percentage of respondents are from tho priv te business sect . In this study sa 'e, private business is proportionately the most frequent employer of graduates in each of the three types of programs. Furthermore, the proportion is highest among employers of rehab-votec alumni, followed by two-year college graduates and finally the four-year college graduates.

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The results of this study all point to positive findings. The expansion in the postsecondary education of hearing-impaired persons is paying off. According to the employers in the sample, the postsecondary programs are providing an adequate technical preparation to their graduates. This evaluation agrees with Bressler and Lacy's hypothesis as to the higher salary commanded by hearing-impaired graduates. The authors, in a 1980 study, speculated after ruling out other factors, that educational advancement appear to be the factor explaining the salary position of the hearing-impaired employees compared to the other disability groups/members and the non-handicapped included in their investigation (Bressler & Lacy, 1980).

Although limited in the generalizability of its results, more of this type of research is what is needed at this stage. Such research can provide indicators and valuable insights into changes in job opportunities for disabled people. It can also record employers' suggestions on ways to promote the hiring of hearing-impaired individuals. This type of information is necessary for the postsecondary programs to keep abreast of changes in the job market and the demands created by new technologies. Research can also provide guidance to the vocational rehabilitation counselors efforts in advising their clients and in planning their placement efforts.

The recognition of the role of employers and the useful suggestions they can offer to promote the hiring of hearing-impaired individuals has finally been recognized. In several states, the extension of advocacy groups to include employers is an excellent step to support and enhance vocational rehabilitation and postsecondary programs' efforts to secure good occupational opportunities for hearing-impaired individuals.

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TREATMENT ISSUES FOR DEAF ADOLESCENT VICTIMS OF SEXUAL ABUSE

FLORRIE BURKE

One out of four girls and one out of seven boys will be sexually molested before age eighteen. The risk factor might be higher for deaf youngsters although we do not have statistics available. There are particular problems to be encountered when working with the special population of hearing-impaired adolescents. There is often a "systems breakdown" when the client in question is hearing-impaired. Normal procedures and protocol such as confidentiality and appropriate family in: vention are frequently abandoned. Case management and in. -agency collaboration often become the responsibility of the treatment provider and a confusion of roles ensues.

Sexual abuse, child sexual abuse in particular, includes many different crimes along a continuum. At one end of the continuum we might have a child who is cornered once in a public place by a stra--er and lewd suggestions might be made and the child might escape. At the other end of the continuum we might have a child who is sexually victimized over and over again for a number of years by someone who is very close to that child.

There are an estimated 200,000 to 500,000 sexual assaults on female children from age 4 to 13 each year. This doesn't include boys and it doesn't include girls under the age of 4 or over the age of 13. Sixty to ninety percent of the victims are girls. We think that this is not quite accurate. There are probably more boys, but these cases are underreported. The molesters are men in 97% of the reported cases. Again, the number of women who molest is going up, and we don't think it is happening more often, but that it is being reported more. In the whole field of sexual abuse there is more awareness, not because there is increased abuse, but because there is more reporting.

Offenders tend to be young. Most child molesters .ommit their first molest by age 40, 80% by age 30, and three-fourths of the offenders are known to the children. In 50% of the cases children will be molested in their own homes. What I am trying to say is that the problem is pervasive. It can happen anywhere, anytime, to anyone.

There is a study that found that 33% of abused children showed no overt reaction to the sexual abuse. This is an area of conflict for us, and it is certainly something that we have not figured out. Is there always a negative reaction? Is the impact traumatic? There are a number of factors to consider here, but we think that one of the important things is to think about the term "overt". The child may, in fact, have many internal reactions to the abuse that she or he chooses not to share with others. As professionals we sometimes confuse this withdrawal and silence with the idea that the child is dealing with the abuse and trying to forget it. A case in point is a six and one-half year old boy we are currently treating who was seriously physically abused and then sexually molested at age three. Following the molest, he was in a coma for a number of months. When he came out of the coma, he was happy and smiling and has never referred in any way directly to the molest or the abus . His mother, however, was convinced that something this traumatic would show up and so she took him to a mental health clinic. We don't know if it was because of the boy's deafness or his presentation, bu. the clinicians there said he was adjusting fine and obviously he had forgotten about it. The reason that we are seeing him now is because he is drawing pictures of males and crossing out all of the genital areas and saying things like, "When I grow up I'm going to be a woman, I'm not going to be a man or bad." He is physically violent toward adults and other children. We think that the treatment of this boy is going to be long term. But this is a good example of someone who does not pick up dolls and start reenacting the sexual molest. However, we cannot assume that it wasn't very traumatic for him.

We think that our particular population of children are very susceptible to incest. We would define incest as any act with sexual overtones perpetrated by a trusted adult whom a child is not able to refuse because of age, lack of knowledge or the context of the relationship. The prolonged abuse by a babysitter or an old family friend may be as traumatic and may produce the same symptomatology as the abuse by a relative. Either kind of abuse produces a feeling of lack of control over one's body, fear and incomprehension. One of the common misunderstandings among professionals is that if there is not intercourse, then abuse really didn't happen. This is not true. A sexual assault such as having to watch a father masturbate can be as damaging to a child as engaging in intercourse. In this paper we will use the words survivor and victim. When we use the word survivor, we mean a person who has been in an incestuous relationship that is no longer going on and victim refers to one who is involved in a relationship that is still continuing.

The research in this field shows that prior to puberty children of both genders are equally vulnerable to sexual abuse. Males, however, are more likely to block the memory of the childhood abuse and females are more likely to have these memories triggered later on when they become sexually active. The majority of offenders are males, but there are women who sexually molest and there are mothers who cooperate either actively or passively with their husband's abuse of children.

We would like to discuss some of the myths of incest. One of the most important and destructive myths is the Freudian myth which deals with incest as a child's fantasy rather than an adult's behavior. Freud backed away from his original preceptions that incestuous abuse caused hysterical symptoms and he changed this to the theory that all chil' 'n experience sexual desire for their parents and this leads to neurotic s .toms. He did not examine the feelings and behaviors of the parents toward their children. There are still therapists and lay persons among us who do not think that childhood seductiveness is learned and that it might stem from incestuous abuse.

There is another myth that dismisses the incestuous abuse as characteristics o. poor minority cultures. This is not so. There is incest in every culture, in every socioeconomic class.

Another myth focuses on the pathology of the offender and attempts to explain incest as a biproduct of alcoholism, schizophrenia, or generalized family violence. Actually, it happens in all kinds of families and often a perpetrator may be a very socially esteemed person and would appear normal psychologically.

Another myth is that the "bad mommy" is responsible for the abuse. This theory tends to blame the mother instead o focusing on the offender.

There is dysfunction in these families. Family dynamics in an incest family are often inappropriate, but this seems to be the effect, not the cause. Many therapists are still influenced by myths. Most incest survivors report some type of inappropriate intervention by a therapist, especially if it is someone who started looking for help more than five years ago. Things are changing now as people know more about this subject and know more about specific kinds of treatment to provide. Many therapists are unwilling to deal with our own feelings about this. In part'cular, the whole field of sexual abuse is something that should cause us to examine our feelings before we attempt to work with clients who have this as an issue. We might feel horror when people reveal the incest to us. We might feel an inadmissible sense of exitement and if we don't confront these feelings, we help perpetuate the myths.

Those are some of the myths, and now we will discuss some of the reality. There is a wide variation among families who experience incestuous abuse, it is almost always repeated, usually on a regular basis for many years. It is common for the earliest remembered incest to 'ave started at age five to seven, although there are many cases where it begins in infancy or toddlerhood and continues on a gradually escalating scale often including various forms of penetration and frequently reaching a crisis during puberty. When a boy or girl approaches puberty, the dynamics change. Usually boys can extricate themselves from the incest during puberty. Girls try to tell someone because they become fearful about pregnancy or that the offender will move on to a younger sibling. Sometimes this threat of telling is enough to end the incest. But sometimes it is not. Sometimes the family controls are so tight, that this kind of thing continues through generations. Sometimes the abuse is a part of the total complex pathology which might include drug abuse, violence, psychotic behavior, etc. Sometimes the incest also involves severe physical abuse and threats of death.

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People wonder how and why this happens and continues for years. The dynamics are so complex and child abusers often use subtle forms of coercion. This makes it very diffcult for a child to say no. If one is able to enlist a child in some sort of forbidden and yet desirous behavior, one can ensure compliance and get it on the part of the child. The offender will tell the child that she is special, the game is their secret, it is happening because he loves her and he can play on the child's need to be loved and the fear of losing what is sometimes the only affection a child knows. We think that this is particularly true with our population of kids. They are often so isolated within a family, and this becomes the only closeness, the only physical closeness and it is very confusing to the child. As the behavior escalates and the child gets older, the child may realize that he/she has bargaining power over the adult and this becomes a reverse power dynamic. Then what happens sometimes as the abuse continues is that the children will start to respond sexually to the stimulation and this becomes very difficult for a child because offenders can then think their behavior is justified because the child is responding. The victim in turn perceives this response as a betrayal of his/her body. Then later when we treat adult survivors, their body image and self-concept is really distorted and we think it stems from this feeling of betrayal by their bodies. When children try to get help, the results are often disas:rous. Young children do not know the language for what is happening and their attempts to communicate are often misinterpreted. One way children handle the secret is to split themselves off and just leave their bodies so that it is like another person is there being abused. They are motivated by the fact that they have to maintain some kind of normalcy or the family might fall apart. They might try to be perfect and all of the bad feelings are split off. On the other hand, some will deny all rules of society and become very bad and run away, act out permanertly, be involved in the courts, early marriage, babies, etc.. Children may forget a lot because they organize tremendous defense efforts to block awareness of the incest. They try to block it from a hostile world, hostile because the message is that this is not okay. There is a tremendous amount of energy generated by these youngsters to keep their anxiety from showing and to maintain an appearance of normalcy. Victims and survivors have developed great strength in order to survive. Sometimes the unacceptable knowledge of incest will be blocked from their memory until the behavior has ended. But it resurfaces later during a life crisis or something that is similar. Anything can trigger it and memory of sexual abuse is a large part of the treatment. It is not very common for someone to have complete memories and there are specific ways of working with people to access those memories. The therapist needs to go very slowly and follow the pace of the client. There are reasons that people use these defenses and block their memories and we have to be respectful of that.

Usually in the beginning of a long term incestuous relationship children don't know what is wrong. They might be bribed, they might enjoy the pleasure of adult attention. The child learns quickly that this must be kept secret. The child also learns that this is a bad secret and by keeping the secret the child is in some way bad. There is not a clear understanding as to why they are bad but this feeling does get internalized sometimes and later they learn they are bad because they broke a taboo. However, since this is often the only love and affection that a person gets in their family, it is very confirming.

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In addition to the more common indicators of abuse there might be some other things such as phobias of men and other individuals, sleep disturbances, excessive bathing, splitting behaviors, obsessions or phobias regarding sexual matters, public masturbation, seductive behavior, chronic urinary tract infections, venereal disease, or bleeding. When you are working with children, adolescents, and adults who have been abused it is necessary to proceed slowly and allow the client to have some control. The whole memory is usually not accessible and might be buried if the therapist shows signs of being overwhelmed or not believing. In the literature and in our personal experience we know that when a mother or another important person does not believe the victim or the survivor, this is indeed more traumatic than the molest itself. If a therapist finds him or herself in a position of not believing, then maybe the client should be referred out. It is also important in treatment to remain calm and accepting and keep in the back of your mind that this happens to many people, it is painful to discuss, but people can and do recover, and we must provide a safe place for the person to tell details to a calm professional who will not get upset and who will respect the pace of the survivor. Anyone in this field knows that we hear some pretty horrendous things and when we think we have heard it all, the next d, we hear another story that is more horrible and it is really important to be calm and accepting and not be overwhelmed. The tendency is to want to get all of the facts about what has been done and in our roles as therapists this is not as important as getting more information about family dynamics, etc.. We are mandated to report, we are not mandated to investigate. People often want to know how to ask about abuse. If it is a child or an adolescent, the therapist can just routinely ask if anyone has touched them in a sexual way. Be direct. When we beat around the bush, it just perpetuates the idea that it is not okay to talk about this and it sets it up for the client that here is another person who is not going to believe him/her, who doesn't want to hear about it, so it must really be awful. We need to be willing to be right out there with it. We want to underline the fact that we need to try to be at ease with this. We are never completely at ease, but as much as we can, we should examine our own feelings so that we exhibit the sense of calm and comfort that makes it okay for the client to talk about it. When we discover that there is incest in the family, we must assess the family situation carfully. Often the systems that are set up to protect children can do a lot of damage in reality. Someone gets removed from the home. More often than not it is the child and this reinforces the idea that it is something that the child has done wrong. Our job, we think, is to work closely with other people in the system to make it go as smoot.ly as possible. The important thing is for the child not to feel guilty. As therapists we need to be able to approach the whole family with some kind of compassion and again, that means examining our own feelings. If we feel that we have so much anger that we can't possibly face this family, that we just want to strangle this father, we are probably not the person to deal with the family. It is important to determine who in the family is the most supportive of the child and can offer help to the child. The legal situation has to be carefully explained. This is very sticky. You tell me your secrets, you tell me your most personal things, and then we are going to report you to the authorities and all hell is going to break loose and how can you trust me and how can we continue to work with you? This takes an enormous amount of skill and tact and caring to be able to manage all of these things and it can be done.

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One of the ways that it can be done is to be really straightforward and explain the whole process to the family. Explain the legal situation, don't be secretive about it, you tell them and it can work out. It can also be dangerous and you need to assess that. You can be dealing with some very dangerous people. The number one thing is that the children need to be protected from further abuse and they need to get, clear explanations every step of the way as to what is happening. It is not fair for deaf children to report something, have someone leave home, be besieged with questions, go to court and not have all of this process explained. If we in our particular work cannot do that, we need to find people who can. Efforts should be made to reinforce different family alliances because there will be disruption. Often the deaf child is already feeling isolated and if s/he has been in a long term incestuous relationship, s/he is feeling even more isolated and we need to not reinforce that.

When we talk about key issues in treatment for victims of sexual abuse, we talk about control and autonomy. This is particularly true when we are talking about deaf adolescents who have been victims of abuse. They have had controlling authority figures telling them how to live, what to do, what to say, what to sign, etc. and if we as therapists become controlling, then we are just one more abuser. We really need to empower a client and work very hard on that. These survivors have lost control, they have lost their power, and it is our charge to try to give some of this back. In cases of sexual abuse, most people feel more comfortable with female therapists. We don't think that this is true in 100% of the cases, as we look upon my male co-worker here, but do think that the literature supports this in a great number of cases. And again, like the whole field of sexual abuse it is because of very subtle, complex dynamics. Sometimes male therapists might feel some guilt about being male, considering what has happened and they work very hard at overcoming this, by being nice guys or there might be discomfort on the part of the female victim and because of these issues, the real issues get lost. If a female client requests a change to a female therapist, we don't think we as mental health professionals should call this avoidance defensive behavior. Sometimes it is healthy, it is a positive sign of taking control that someone is recognizing her own needs. When working with abused children we have to remember that some have built a protective wall of denial that helps to keep them safe. We don't need to demolish that wall in one full swoop. We need to take it down brick by brick because this wall serves the purpose of keeping children safe from what they either expect or from what they have already experienced. Other children don't build a wall, they just create other defenses and act like nothing bothers them and they are not afraid of anything. This makes it more difficult for them to acknowledge the hurt and that is the way that they protect themselves. Again, lower the wall slowly because it has provided safety and we don't want to frighten people. It is very hard for children to admit abuse if it means admitting that their parents are wrong. It is much easier to say, "I'm wrong, I'm bad, I'm not perfect," than to say, "My mother and father are wrong, and bad and not perfect." Because of this dynamic, a lot of children grow up thinking that it is their fault. Because it really is easier than to think that it is your parents.

We would say without any hesitation that all abuse is a problem with adults and not with children. Most children are taught not to talk about the abuses outside of the home. The crucial thing about sexual abuse is not exactly what occurred, what the specific abuse was, but rather, the impact it has on a particular person, how it was explained to that person, and how it affected that person.

There are some variables about the impact on a person that we would like to run through. The first variable is the relationship between the offender and the victim. This is an important variable. The closer the relationship, the more this is a trusted adult, someone depended on to take care of, to provide love and affection, the harder it is to understand the molest. A second variable is the duration of the abuse. Another variable is the type of sex play involved in the molest. A fourth one is whether or not there was physical abuse along with sexual abuse. This has an incredible impact on a child. The fifth variable is the age and developmental level of the child. And the last variable which is very important, is the reaction of the people around the child. This is what was meant before when we said that the trauma of not being believed can be worse than the molest.

There is no excuse for abusing children. It is important to look at the reasons, but not as a way to excuse what happened. One can say that father molests because he doesn't have a job, because he drinks, because he's crazy, etc.. If we zero in on that, what we do is we get the adults off the hook and we keep the children feeling responsible. Of course, we can't overlook those factors, but when we use those as excuses, then we are overlooking something that the child needs.

In treatment, there are a number of things that we as therapists need to be able to do. One is to show and be able to exhibit clearly a regard for the client. We also need to establish credibility. Therapists can say to the client, "I have talked with others who have had things like this happen, you are not alone. What do you know about being here, do you know why you're here, how do you feel about talking to me about what happened?" The child needs to know that the therapist is honest and by being honest we need to tell them what we are going to do about the reporting process and about what might happen. The child must know that we want to help them. We need to try to neutralize the psychological trauma and return some control to the child. By doing this we can ask opinions, we can tell the outcome of decisions, how decisions are made, and not just be giving information, but be getting something back from the child also. This is one of the only ways to return some power to the client.

When we get a story from a child or adolescent, we need to look at any changes in the lifestyle of the child which have occurred since the assault: changes in eating, sleeping, dreams, nightmares, a child's concentration in school, thoughts of the assault, how often these thoughts come into the persons mind, physical symptoms, illness, how the family is handling it, etc.. We need to be able to say to each other, as therapists, that: "this is difficult;" "this is tough;" "I have a lot of feelings about this;" "I need to talk to you about it;" "I need consultation;" "I feel hopeless;" "I feel helpless;" "I feel disgusted;" "who can anybody trust?" "I think we really need to put ourselves out there and get help from each other."

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Some specific cases ich illustrate some of the problem areas of working in this field are prese d in the following section.

Problem: Multi--gency coordination to insure protection of the ado-lescent. We would l'ke to tell you about a 15 year old girl whom we worked with who was molested by her father and exploited by her mother. When we say exploited, we .ean tha. the mother was often involving the media. This girl had a dramatic presentation and a dramatic hearing 'oss, and the mother would buy her clothes that were age inappropriate and then exploited her in a number of ways. She was the only one with a disability and she was also the family scapecoat. There were conflicting 'alues in this family. They were a very strict fundamentalist religious fa-lly, but there was sexual acting out, and this was very confusing. The girl made a report of her father's molest and she was removed from her home. She developed a number of problems; she developed an eating disorder, she lost an enormous amount of weight, stole food, binged, threw-up. She made a number of suicidal gestures, she was constantly threaten'ng to run away, she was stealing, lying, and she was acting out sexual'y. She was hospitalized ar.d she responded al ight to trea - ment for a while, then she started to regress again and started acting out in the hospital and the psychiatrist on the case said: "Well I think that she needs to go to another foster home." The social work. and our staff asked: "What makes you think that this is going to be more successful than the other foster home?' ar.j he said: "Well, we'll just see. . ." We predicated failure, and there was failure, she ran away, she got into trouble, and she was ultimately put in, not juvenile hall, but a receiving center at juvenile hall, which is voluntary and is the place to go before placement in a group home. We wanted her to go to a group home that had some treatment. While she was in the receiving home, she ran away. No one could stop her, she was gone and we didn't hear from her for a year. She had been hospitalized with severe pelvic inflamatory disease and we had real concerns about her health. One year later she called ar.d set up an appointment, but never showed up. We have no idea where she is. The reason we are bringing up this case is to show how difficult it is to coordinate services and ensure protection of the child or adolescent.

We worked with the residential school staff, with three sets of foster parents, with the family of or n, with the staff at the hospital and the psychiatrist, with CP workers, and with her public school staff. We tried to get som body else to do case management so that we could stay her therapist, but as most of you know when there is a deaf client involved, most other agen-cies change procedures and expect us to ta. 3 over and be the case manager, and that dilutes the therapeutic relationship. We weren't able to protect this girl, we just weren't. There were too many systems involved and not everybody wanted to hear our thoughts and evaluation. It was unfortunate because this girl was really at risk for substance abuse, sexual acting out, suicide and it was a very tough case.

Problem Two: Undue stress and trauma placed upon a family due to misin-terpretation and Problem Three: Family therapy when reunification is appropriate. Most of you are familiar with the television program ": something About Amelia." It was shown last year for the first time and recently repeated in California. It was a very good television movie about incest.

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Following that movie there were a number of reports made and this particular girl, who was 14 at the time made a report to her cottage counselor at a residential school for the deaf. She reported that her father touches her in a way she doesn't like. This was reported to Child Protective Services who immediately sent out a new worker. The new worker was really thrown off by the fact that this girl was deaf. A professional interpreter was not called in. The police was there taking the report. We received the report and later we went over it with the girl, and all she kept saying was, "I never said that, I never said that." The girl would say things like, "He pats my leg." In the written report this became, "He strokes my thigh." She said "I feel afraid that he will move up toward my vagina." In the written report it said, "He strokes my thigh and moves his hand up to my vagina." That whole subtle concept of "I feel" was lost. The written report was very different from what the girl had said. She reacted very strongly to the written report in a negative way by saying, "I didn't say that, he didn't do that, I didn't mean that." What she did mean was that she was very uncomfortable with the way her father was touching her. It made her feel uncomfortable. She was immediately removed from her home, no contact allowed with any family members. Child Protective Services called us, the father's attorney called us and tried to make us promise that we would not discuss this issue with the family although they were being referred for treatment. We said that we were not willing to do that. The father was both angry and feeling very hurt and misunderstood and the girl was feeling fearful because she had been removed from the family and hadn't been able to talk to her stepmother, etc.. So we met with her and we met with the family and tried to assess if was safe for her to go home, what had really happened, how they were all feeling, etc.. It turns out that there was a great deal going on that had nothing to do with sexual abuse. What was going on was that this girl had just started to mature physically and her father was still treating her as if she were 10 and she was not feeling like a little girl anymore. What he was doing was inappropriate, but it was not sexual abuse. It made her feel uncomfortable, and it was important that she be able to tell him and that he know and understand that, but this incident was so blown out of proportion, he was taken to court and the family was greatly disrupted. This is one of the hardest families we've ever had to work with because the father was so defensive and so angry and hurt that this girl would say these things. We arranged to work weekly with the girl individually, to work weekly with the parents and then to work with the family together a couple of times a month. They were court-ordered for six months of therapy and they stayed in treatment for a year. It was a difficult case, but it is a good example of how things can really blow up quickly, we think this happens with deaf children because people just don't know what to do. It was unfortunate. We don't think that all of us in this field are on a witch hunt trying to uncover sexual abuse every place we go. We don't think that this was sexual abuse. We think it was inappropriate touching and we think it was an inappropriate response to a young girl who was all of a sudden feeling her own sexuality, but this case didn't need to have the legal intervention and stigma attached to it. This case points out the need to educate other agencies about deafness, and also serves to caution us not to jump to conclusions.

Problem Four: Differences in the treatment of male victims. Preparing the victim for legal proceedings. We worked with a 13 year old boy who in addition to being deaf had a seizure disorder and was learning disabled. He

was molested several times by a male babysitter who was a few years older. He was threatened with a knife and his 5 year old brother was also being molested by the babysitter in his presence. The family found out because our client's behavior became so bizarre that they started asking questions. The family pressed charges and from the time of pressing charges to the time of the court date, this boy showed regressed behavior. He was fairly psychotic when we saw him. He would be in and out of a psychotic state and we provided supportive therapy for the parents as well as individual therapy for the boy. This boy was difficult to work with because of his psychological state but some of his conflicts were that the abuse felt good to him amd he felt guilty about that. He also was conflicted because he di' 't have any friends and he wanted a friend and thought this was the way to get one. Another problem was that he couldn't protect his 5 year old brother and felt very guilty about the abuse to his brother. He was also embarrassed around his father regarding questions of masculini, why he let this happen, what did this mean, etc.. He had a great fear o being hurt by the babysitter. We worked a great deal on his self-image, his sense of inadequacy and his lack of power. He really decom-pensated when it came close to court date and we did a lot of work with this. We drew models of the court, we built models, we explained what was going on and we took him to the court. The particular court system that he was involved in has child advocates so we hooked him up with one of those, we got an oral interpreter and we got a sign language interpreter because he used both modes. At the last minute, they settled out of court and in a way this was too bad for him because he didn't really understand and he felt like things were not finished. He didn't have closure or a chance for mastery. We didn't finish treatment as the family moved to a very isolated area of northern California where there are no services for the deaf educationally and certainly not in mental health. The parents called us a while ago and said that he was being hospitalized. We imagine that he is in bad shape, and we don't think it is just because of the abuse, but because of the complexity of his problems and that the abuse was just more than he could cope with. But again, these cases take an enormous amount of time, because we are working with teachers, working with attorneys and working with social workers, etc.. It is difficult to do a large percentage of these cases in a caseload although that often happens once one becomes identified as someone who can do this kind of work.

Problem Five: Court-ordered therapy. Working with family denial. We worked with a 17 year old who reported repeated molest by her stepfather. She has a deaf family. She reported the molest to school personnel who then reported it to CPS and she was removed from the home. She did not go to school for six weeks supposedly because the foster home was too far away. She didn't know how to get to school and became unhappy that many of the school personnel knew about the incident, that kids gossiped about it, and that her family was frantic. This very bright young woman gave an extensive police report with many specific details. This included nudity and exploitation in the family. This girl is 17, beautiful, bright, and very active in school. However, she never goes out socially, never. When she went to court, she recanted. She took back the story. Her stepfather was sitting right there and she told the judge that she made it up. She was mad because her parents were not taking her to doctors appointments and not paying enough attention to her. The family was court-ordered for family therapy anyway, because the

Judge believed that the abuse was happening. When a therapist gets a court-ordered family, it is very difficult because they don't want to be there and they don't want to work. This family came in angry and this was tough. We worked with the girl individually and worked with the parents as a couple and then we worked with all of them. We did a combination of things. They were court-ordered for six months of treatment. We decided that we weren't going to get anywhere if we kept focusing on the molest and whether it had happened or not. Our client said .t hadn't, so we left that alone for awhile and worked on the general dynamics of the family and the fact that she needed some autonomy. We did some good work, but underneath it all was this whole issue that wasn't really getting talked about, except in sort of couched terms, bec~use every time it came up th..s thunder cloud would appear and they would all get into denial. Then our client turned 18 and they didn't come anymore oven though the six months weren't up. We don't know what is going to happen in this case, but we don't think that she made it up. There are many classic indicators in this case and we suspect she reported accurately. Perhaps when she is able to leave the family, she will be able to report the truth.

Problem Six: The guilt of the adolescent when the perpetrator is imprisoned. Sex education as part of the therapeutic intervention. The last two cases that we are going to discuss are about adolescent girls whose offenders have been incarcerated. This becomes a major focus of treatment.

In one of the cases the stepfather was the only consistent male in this girl's life. She was devastated by the fact that she thinks she sent him to prison, and that is something that has to be worked out in therapy. Following the incest, she became a girl who acted out sexually, and had incredible anger towards her mother for not protecting her. In treatment we focused on adolescent issues between the mother and daughter, the girl's anger toward the mother and the mother's need to recognize what this girl needed to do in order to grow up and be an adolescent and then an adult. We also did a lot of sex education. There wasn't very much. After one year, she is at a point where she understands and doesn't feel so guilty about the incarceration.

The other girl we started working with a few montns ago. She was involved with her grandfather in a very 'ong-term incestuous relationship. He also molested some of her friends and this has caused her tremendous guilt. Her mother, who is an alcoholic, was unavailable to her. Yet, she typically turns herself inside out to get her mother's approval. The first time we ever saw her she said, "I know you want to talk about what happened with my grandfather, it's over, it's done with, I'm not going to talk about it anymore." We respected that at the time and tried to build trust with her. During the third session, she came in and it all came out. We think it is because we didn't push her, she knew we would talk about it, and she really needed to talk about it. This is a new case and there are many things going cn. She makes suicidal gestures, she acts out and she doesn't make connections between feelings and behaviors.

We must look beyond individual cases to the conditions in our society that form, permit and encourage offenders, most of them male, to act out violently toward women, children and vulnerable men. Wife battering, child abuse,

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Incest and rape are part of the same problem. They are crimes of power and coercion which help maintain the power structure of our patriarchal society.

As a society, we need to educate ourselves, clarify our values and then practice them. We need effective treatment programs for child victims, secondary victims, adult survivors and offenders.

We must confront incest. Many survivors have broken the silence to tell their stories, challenge misinformation, share their pain and demonstrate their reclaimed power. The feminist movement places incest in a social and political context rather than looking at it as an exa le of isolated familial pathology.

It is essential to talk to children, to educate and empower them. This is even more important for our deaf children.

An outgrowth of our work in sexual abuse and something we have wanted to do for a number of years is to develop a child abuse prevention program for deaf children. Last year we contacted an organization in San Francisco called the Children's Self-Help Project. We received training from them and received help with a grant proposal. They hired us as "Special Needs Consultants" and we are adapting their excellent curriculum which is to be used for the hearing impaired. The curriculum covers preschool to high school. We are training five .eams of people who sign to present the program in classes for the deaf in our area. It will then be available to other people throughout the country. We are thrilled and excited that deaf students will finally have access to this information.

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DEVELOPMENT AND iMPLEMENTATION OF SE, JAL
HEALTH POLICIES IN   SCHOOL SYSTEM

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In recent years one of the most challenging areas of
law pertains to student rights to privacy regarding sexual
health issues.   Today ignorance of the law is not bliss.
Such ignorance often results in the denial of legal rights
of individuals and/or the destruction of professional
careers.   The necessity to deve op written sexual health
policies is vital in school systems today. A proven process
for sexual health policies development and implementation
will be outlined.

Today the school admininstrator is faced with legal issues their predecessors sel om, if ever, had to confront.   Issues regarding student rights, parental rights, the right of confidentiality and the right of privacy are now common concerns of most school administrators. It can no longer be taken for granted that employees understand their rights and responsibility in making sure that they are not denying the rights of others in their care. In a court of law, the statement "I didn't know" is no longer acceptable. School systems are expected to know the law and to follow it.

In recent years, one of the most challenging areas of law pertains to the student's right to privacy regarding sexual-health matters.   In the past decade, tremendous changes have occurred regarding this area of law. Examples of these changes are found in the following court decisions:

o The 1973 U.S. Supreme Court decision granting a woman the right to
obtain an abortion.

o The 1977 U.S. Supreme Court decis'on regarding the right to distribute contraceptives to minors.

° The "mature minor" doctrine which permits the court to determine
that a mature minor can consent to medical treatment without paren-
tal permission.

These recent court decisions make it even more imperative that school admin-
istrators be well informed of the law and have legal counsel available.

It was this appreciation of the legal issues that prompted the authors to
raise the question of the need to develop a sexual health policy for the Model
Secondary School for the Deaf, Pre-College Programs, Gallaudet College. Dr.
Robert Davila, Vice-President of Pre-College Programs, suggested that the
authors investigate the need for such policies through the following steps:

° Conduct a sample nationwide telephone survey of the different
programs serving deaf youth.

° Contact the State Departments of Education in Virginia, Maryland,
and the District of Columbia to obtain state statues.

° Research the most recent Federal Regulations.

° Compile a report for his review and discussion.

The authors proceeded to carry out this plan and uncovered the information to
follow.

Fifteen day, residential, and mainstream programs serving deaf youth
across the nation were randomly selected and telephoned. The head admin-
istrator of these schools reported that they did not have any formal,
written sexual health policy statements. Each expressed an interest in
the Pre-College Programs' efforts and final products.

The research on the State Department of Education statues revealed that
the State of Maryland had detailed policy statements regarding sex education/
health issues, while the State of Virginia policy statements were very vaguely
stated. The District of Columbia reported that policy statements were being
developed.

Review of the Federal Regulations indicated court decisions regarding the
rights of minors to have access to contraceptives and abortions without paren-
tal consent. Under Title IX and Title X, it was patently obvicus that it is
illegal to discriminate against students who were pregnant or married.

This information was reported to Dr. Davila and he decided it was neces-
sary and appropriate for Pre-College Programs to take the lead in developing
sexual-health policies.

Below is an outline of the process followed by Pre-College Programs. Each
of these steps will be discussed in detail.

PROCEDURE FOR DEVELOPMENT OF SEXUAL-HEALTH POLICY

O Selection of interna' committee:

   Made up of supervisory, representatives from each MSSD department

   Committee chaired by superintendent or designee

O Identification of areas that policy is needed:

   Examples:

   Confidentiality Issues
   Contraceptives
   Abortion
   Intimate sexual relations
   Force' sexual activity
   Married students day/dormitory
   Pregnant students day/dormitory
   Sexual abuse
   Sex education position
   Sexual signs
   Sexually Transmitted Diseases

O Research the local, state, and federal laws regarding identified areas

O Develop draft policy statements

O Administrative review of draft

O Legal review of draft

O Revision by committee

O Return for administrative review

O Review by :

   Faculty/staff or faculty/staff committee
   Student committee (student government)
   Parent advisory committee or selected parent group
   Sex education advisory committee
   School Board

O Revision by committee

O Final review by legal counsel

O Submission to school board

O Inform and educate all parents, faculty, staff, students

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SELECTION OF INTERNAL POLICY COMMITTEE

The sexual-health policy committee operates best when the membership con-
sists of supervisory staff representing each department or area in the school.
The superintendent or his/her designee should chair this committee. The
authors have tried different models with various schools and find supervisory
staff best suited to the challenge of policy development.

It is important that the committee identify, understand, and agree to the
scope of the tasks involved in the development of this unique policy Some
committees best work by dividing up the various tasks and accomplishing these
through small group work that is reported back to the committee.

Legal counsel must be provided to the administrator and the committee at
the beginning of the process in order to avoid unnecessary tasks. Without
legal counsel, the committee could propose policies that are not legally sound
or reflective of local, state, and federal laws.

A school board member should be involved in the initial stages, as well.
This can be accomplished by direct membership on the committee or by periodi-
cal update by the administrator or designee.

IDENTIFICATION OF ISSUES FOR POLICY DEVELOPMENT

The areas to be covered in policy statements will vary from school to
school. Some systems may have developed policies covering some issues
discussed previously, while other schools may have no written policies. The
committee must identify those areas which it deems needed or absent from the
program.

There are several issues of particular interest in residential schools.
One of these is the concern for confidentiality, as it most often represents
an area of conflict for professionals in systems. Another issue is regarding
the pregnant student and appropriate placement for the continuation of educa-
tional and/or residential programs.

In essence, no one has confidentiality in a school system. Psychologists,
counselors, social workers, and nurses operate under a code of ethics, but
this does not represent the law. A number of court cases have affirmed the
right of the head administrator to have access to any and all information
regarding students in order to ensure and maintain the daily operation of the
school. The authors suggest that this lack of confidentialty can be viewed as
more positive than negative in that it provides the professional staff the
opportunity to respond to students through "team effort." This parternship
will allow the staff to operate in the best interest of the students.

Pregnant students and the dormitory environment present a challenging
situation for the residential program. Several residential schools have
attempted to limit or prevent a pregnant student's participation in the dor-
mitory program based upon their concern for her protection. However, this
reasoning has not been upheld when viewed from a legal preceptive. Current
law requires that all decisions must be made in conjunction with the pregnant

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student, her parents, the student's doctor and school health services. Maintenance In a dormitory may be the most appropriate decision with consideration given to ways to respond to the social and medical needs of the student.

REVIEW OF DRAFT

A critical step In the process of sexual-health policy development and implementation lies with the review of the draft by the appropriate groups who make up the school community. The purpose of this review is twofold. First, it eliminates any surprises. Second, it provides the school community with the opportunity to offer input and feedback on policies. The following groups are examples of the school community: faculty and staff committees, student government officers or committees, parent advisory boards, school boards, and sex education advisory committees.

These representative groups can provide practical suggestions. Most schools have these and other groups that want to be a part of the success of the school programs. These groups should be informed that their ideas and suggestions are listened to and will be reflected In the draft changes, where appropriate.

Once the draft has been reviewed by the school community, the internal committee will include the suggestions in a revision. The revised draft should be reviewed again by legal counsel. When it has been determined that the revised draft is legally sound, the draft is ready for the final step in the development process, approval from the school board. This step should not be difficult, if the board has been involved and informed from the initial stage.

IMPLEMENTATION PROCEDURES

The policies are not worth the paper they are written upon unless they are appropriately implemented by the school community. This means that every parent, student, faculty and staff member must have an opportunity to discuss and understand how the policies apply to them. It is not enough to give a copy of the policies to the school community. Ways to educate and inform parents, staff and students will be explored.

Parent Implementation Approaches

The geographical dispersement of parents will often influence the types of approaches used to share the policies with parents. If the parent population is local, then meetings at school will represent one possible option. A copy of the sexual-health policies should be mailed to each paren' with a cover letter explaining the purpose, procedure and a contact person to answer questions.

If parents are located some distance from school, it may be benefical to hold meetings in a community closer to a group of parents In addition to the school-based meeting. It is important that every effort is made to include and educate the parents. Parents are valued and must be a part of the success of the Implementation.

Student Implementation Approaches

Generally it will take a number of hours to go over the policies with students. Each policy should be discussed with an appropriate faculty or staff member who has good rapport with the students. Often small groups are very benefical in this process. The professional(s) leading the discussion must be well informed about the policies and capable of responding to student questions and concerns.

These discussions may well take place in either the dormitory or academic setting. Students must be given the opportunity to understand everything they can regarding the policies as they can not be expected to follow policies they do not understand.

Faculty/Staff Implementation Approaches

Many well intended faculty and staff members have found themselves and the administration in serious legal trouble by not knowing and/or following the law regarding sexual-health issues for minors and young adults in their care. As the authors indicated previously, this is not acceptable today. Therefore, the faculty and staff members must be provided appropriate in-service training in order to implement the policies and procedures written by the committee.

Depending upon the length and content of the policies, the amount of time for in-service will vary from school to school. Generally, the staff needs a half-day to a full day to discuss and understand the policies completely.

Continued Revision

No set of laws or policies are set in stone. Both change with the events of society and the school system. Thus, annual review and modification of the policy statements become necessary. This critical task can be accomplished by asking the legal counsel to review the policies for maintenance of relevance to sexual-health issues of the day.

An example of how important continued review becomes occurred at Pre-College Programs. When the policy statements were developed several years ago, AIDS was unknown to the general public. The Pre-College policies had to be modified to reflect procedures for handling this Sexually Transmitted Disease.

CONCLUSION

Dr. Lee Murphy, former Dean of the Model Secondary School for the Deaf and current Superintendent of the Indiana School for the Deaf has often remarked, "When you appear in court, the judge asks you two questions. One, do you (the school) have a written policy and guidelines covering the issue in question. Second, the judge will ask if you (the school) followed the policy. If the school representative answers yes to the first question, the school is half way home. If the answer is no to this question, the school faces a very difficult legal situation."

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Today it is no longer nice to have policy statements about sexual-health issues, it is necessary. Although this process requires work and effort in development and implementation, the pay off far outweighs the effort. Sexual-health policy statements provide protection and guidelines for the student, the school faculty/staff and parent. Each will gain in this unified approach to handling a difficult area of school responsibility.

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PREVENTION OF ADOLESCENT SUICIDE
IN THE DEAF POPULATION

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Innovative research described in this article shows that suicide attempts among deaf adolescents have increased at an alarming rate. A prevention package including a film and manual designed specifically for deaf teenagers based on a highly successful prevention model is described. Warning signs, intervention techniques, and theories on the reasons behind todays adolescent suicide attempt rates are discussed.

Shneidman (1961) defines suicide as consciously thinking about killing oneself and the following deliberate action to end one's life. Suicide has been happening since people have lived on this earth. It occurs among all socioeconomic levels, races, religions, sexes, ages and nationalities. People who think about suicide express intense feelings of hopelessness, helplessness, and worthlessness and perceive themselves in an intolerable situation. It is at this point that death seems to them to be the only way out. Adolescents often do not have the life experience to understand that situations which appear intolerable are most often only temporary and resoluble situations.

Between 1964 and 1984, the adolescent suicide rate increased three times or 300%. From 1974 - 1984 it increased two times or 200% (Tishler, 1981). As with other major social problems; drugs, alcohol, unwed pregnancy and running away, suicide occurs at an alarming rate. Madison reports that suicide is the number two killer of people between the ages of 10 and 24 in the United States. Suicide is also the <u>most preventable</u> death known. Education to all parts of the population on the early warning signals of suicide and intervention strategies, which include community mental health resources, can reduce suicide rates among our teenagers a great deal.

A PREVENTION MODEL

Madison (1978) says that one primary means of prevention is a direct educational campaign identifying the signs, symptoms and intervention techniques involved in teenage suicide. Franklin County used to rank second in the state of Ohio for the number of deaths by suicide. To change that, a very strategic educational program was developed and presented to guidance counselors, school psychologists, nurses, school administrators, teachers, parents and adolescents in the school systems. Attendance at most of these programs was mandated by school officials. After 2 years of education to over 100,000 people, the suicide death rate for adolescents 19 years and younger decreased 73% throughout the county. The use of suicide hotlines and community mental health centers increased over 100% for adolescents. Because of this program, Franklin County went from the second highest county in Ohio in death rate by suicide to one of the lowest.

Following three suicide attempts by deaf teenagers in Columbus, Ohio, a multi-disciplinary, multi-agency task force was formed to explore the rate of suicide among deaf teenagers and the training materials available for prevention of suicide in the deaf population. The task force included both deaf and hearing members from Ohio School for the Deaf, the Columbus Public Schools Hearing-Impaired Program, Netcare Corporation, the Community Center for the Deaf and the Rehabilitation Services Commission.

SUICIDE ATTEMPT RATE AMONG DEAF ADOLESCENTS

The task force discovered that there was a void in research focusing on suicide and the deaf population. They also found that there were no education materials on suicide prevention and intervention developed specifically for deaf adolescents. In 1982, the group conducted what we believe to be the first research on the rate of suicide among deaf adolescents.

Surveys were sent to 125 residential and day schools and 71 mental health centers serving deaf clients across the country. Out of a total of 196 surveys sent, results from 100 returned surveys were compiled.

The surveys requested information on the following items: 1) sex; 2) age groups; 3) school year; 4) suicide attempts; 5) deaths by suicide; 6) methods used; 7) geographical region of the country; 8) type of school; 9) school size; and 10) number of clients seen in mental health centers.

Results from these preliminary surveys are depicted in Tables 1-4.

As can be seen, the suicide attempt rate is increasing at a tremendous rate for this population. Results indicated that the suicide attempt rate among deaf adolescents between the ages of 10-24 increased well over 100% during the 5 year period of 1978-1982. The death rate was incomplete due to the sources of information being schools and mental health centers. Better sources for these statistics would have been either the county coroner's offices or the state health departments.

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TABLE 1

Reported Attempts by Deaf Males: 1978-1982

MALES

AGE	'78	'79	'80	'81	'82	no year	
5-9		1	1	1	1		
10-14	6	11	34	37	39		
15-19	10	21	31	35	33	1	
20-24	25	21	28	33	30		TOTAL
subtotal	41	54	94	106	103	1	399

TABLE 2

Reported Attempts by Deaf Females: 1978-1982

FEMALES

AGE	'78	'79	'80	'81	'82	no year	
5-9							
10-14	1	2	11	14	19		
15-19	14	16	26	29	51	2	
20-24	10	11	11	18	21		TOTAL
subtotal	25	29	48	61	91	2	256

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TABLE 3

Percent Increase Between '78-'79 and '82-'83

Attempts

10-14 years old	828%
15-19 years old	350%
20-24 years old	145%

TABLE 4

Methods--Attempts/Death

TYPE	SCHOOL	M.H. CENTER	
O.D.	38	12	
Weapon (Gun)	28	9	
Jumping	9	2	
Hanging	4	2	
Auto Accident	2	0	
CO Poisoning	0	0	
Drowning	0	0	TOTAL
Not specific	5	1	114

Results of the survey show that the types of methods used were highly lethal. Males had a higher number of attempts than females.

After completing the survey and studying the results, the Columbus Deaf Task Force came to the following conclusions:

1) deaf teenagers have the same needs for suicide prevention materials as hearing teenagers do;
2) because the suicide attempt rate was on such an increase, most likely so was the death rate;

3) a suicide prevention program for deaf teens needed to be developed; and
4) further research needs to occur to determine factors leading to such a high rate of attempts.

Madison's (1978) theory of prevention involving education of teenagers, their peers and significant others around the signs, symptoms and intervention techniques was successful in reducing the suicide rate of hearing teenagers by 73% in Franklin County. The task force, therefore, recommended that a similar program be devised for deaf teenagers.

THE MODEL REVISED: A FILM AND MANUAL FOR DEAF TEENS

The task force recommended that a suicide prevention film and educational guide which focuses on the special needs of deaf adolescents using: a) American Sign Language; b) English captions, c) voice dubbing in English; and d) deaf actors/actresses be developed.

Netcare Corporation, with the assistance of the task force and the Ohio State University Department of Photography and Cinema developed the film and educational manual. The film is titled "A Better Way." It is a story about two suicidal deaf teenagers and the struggles they experience. One character, Debbie, succeeds in her suicide attempt; the other teenager, Mike, receives help and guidance which stops him from attempting suicide. The film teaches viewers to recognize the warning signs of suicide and educates them on where to go for help. Deaf and hearing actors and actresses are seen in the film using American Sign Language; voice dubbing has been added for the benefit of hearing and hard-of-hearing audience members. The task force is now in the process of captioning the film.

The film should never be shown without it's accompanying instructional guide which provides the reader with all necessary information on presenting the prevention program. Before beginning the program, the person responsible for presenting it is encouraged to read several books on suicide from the bibliography in Chapter VI of the manual. It is also important for the presenter to view the film several times in advance to know the context and scenes that will be appearing.

The film should be presented to small groups of teenagers. It is important to keep the groups small so all students will have an equal opportunity to express feelings and the presenter can monitor student responses. The film can provoke intense feelings for the audience, particularly a teen who is currently suicidal, has a friend or family member who is suicidal, or has lost someone from suicide. The film should be shown early in the week so teenagers will be able to process the film with professional support at school rather than wait over the weekend to do so.

Two adults should be available during the presentation, thus one can be available to talk individually with a student who is showing discomfort. The following behavior symptoms of discomfort should be watched for: anger, crying, fear, withdrawal, fidgeting, and ignoring the presentation. A counselor, social worker or psychologist should be available to see teens during

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the week of the presentation. Schools may provide a drop-in place for teens to meet during lunch or free time to discuss feelings about the topic of suicide. These impromptu groups should be facilitated by a qualified mental health professional. They are an excellent resource for teens at risk.

The seven lesson plans in the manual are specifically designed in a sequential format. No component should be used in isolation, but rather as a part of the total project, each activity building on the next. It remains at the instructor's discretion to develop specific teaching strategies depending on the language level, educational background, cognitive abilities and social maturity of the audience. The facts will determine how much time is needed for each lesson. Details on how to administer each lesson can be found in the manual.

WARNING SIGNS

Approximately 75-80% of the people who die from suicide every year give clear warning signals (Griffin, 1983). If we can recognize the warning signals and learn intervention techniques, many lives can be saved.

There are four major types of warning signals indicative of suicide potential. In assessing suicidal lethality, it is important to look for a cluster of the warning signals rather than just one signal in isolation.

Suicidogenic Situation: Here the situation is the warning. This usually involves a loss of some kind such as the loss of a significant other (parent, sweetheart, friends, pets), loss of a job, self-esteem. Failure and sudden life changes (i.e., teenage pregnancy, moving) can also be traumatic to adolescents.

Depression: Although most suicidal people are depressed, not all depressed people are suicidal. Signs of depression include changes in a person's psychosocial and emotional state that may contribute to thoughts of suicide. This includes changes in eating and sleeping habits, difficulty concentrating, decline in school and/or work performance, neglecting personal appearance, truancy, increase in drug and alcohol use, acting out behaviors, apathy, fearfulness and sadness.

Talk About Suicide: Teenagers may often give verbal messages about suicide such as "I want to kill myself," "I wish I were dead," or "I won't be here tomorrow," or "Life isn't worth it."

Behavioral Warnings: Behavioral warnings can include previous suicide attempts, giving away prized possessions, withdrawal from normal activities, suicide notes found in poems or journals, crying, vague somatic complaints, choosing suicide as a topic for a paper, drawings signifying death, and quick recoveries from severe depression (Giovacchini, 1981).

INTERVENTION STRATEGIES AND REFERRAL SOURCE

Once warning signals are recognized, it is imperative to ask the teen if they have ever thought of hurting themselves. Suicidal teenagers often may be

Immobilized from getting help for themselves and are relieved when someone offers them the opportunity to talk about their feelings. Here are some suggestions for interventions:

1. Develop a sound relationship with the teenager by listening without judging.
2. Assess the teenager's primary mode of communication and utilize that mode. If the mode is sign language and you are not a fluent signer, use a qualified interpreter.
3. Don't assume the teenager understands what you are saying. Ask them to repeat what you have said to clarify their understanding.
4. Assess any immediate risk for suicide by asking these questions:

   a. Have you ever thought abut hurting yourself? (Be sure to really listen to the answer.)
   b. Do you want to die?
   c. Do you have any plan on how to do this? (Does a plan exist?)
   d. When would you do this? (Is time specific?)
   e. What would you do? (Are details specified?)
   f. What method would you use? (How lethal is it?)
   g. How available is this to you? (How accessible it is?)
   h. Who lives with you and when are they home?
   i. What would keep you alive?

5. Be confident and take control.
6. Let the teen know this is a "secret you can't keep."
7. Do not act shocked or scared.
8. Do not leave the teenager alone!
9. Mobilize resources to keep the teenager from being alone. If possible, utilize resources that are fluent in the same form of communication.
10. Refer to a local community mental health agency that has comprehensive services for hearing-impaired persons and follow up on that referral. If no such agency in your area exists, advocate for your area mental health agency to initiate programs to serve the hearing-impaired population.
11. Help the teenager identify personal resources and area mental health resources. Make sure the teenager knows how to contact these resources, and where these resources are located.

By no means should the intervenor assume total responsibility for the suicidal team. You are the first step to saving a life. Referral to a professional who is highly skilled in dealing with this situation is a must. Involvement of as many people as possible is mandatory to saving a life.

WHY TODAY?

For deaf adolescents, as with hearing teens, families are more mobile today. Deaf adolescents have more educational options than ever before and thus, many experience shifts in environment more than we have previously seen. Divorce rates are up and the rate of divorce among parents of handicapped

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children is higher than that for the general population. Job opportunities are more depressed than those for hearing teenagers. Due to general increases in family mobility and fewer families with both parents at home, the availability of support systems for adolescents has decreased. Problems in communication make accessibility to support systems even fewer for deaf adolescents. While there are not many good role models for adolescents today, deaf teens have even fewer adult role models. There are often very few deaf adults employed in schools and counseling centers, seen on T.V. or in movies.

"A Better Way" is available for distribution. Funding for the project was provided by the American Legion Child Welfare Foundation, Ross Laboratories, Ohio Bell Pioneers, The Columbus Foundation, The Society of the Deaf, The Ohio Department of Mental Health, Ohio Rehabilitation Services Commission and the Suburban Ministerial Association.

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This material has been selected from "Better Way," A Suicide Prevention Program for Deaf Adolescents and Adults (in press) and is presented here with permission of the authors from The Adolescent Suicide Prevention for the Deaf Task Force; Columbus, Ohio. (see Appendix).

APPENDIX

"A BETTER WAY"

A SUICIDE PREVENTION PROGRAM FOR DEAF ADOLESCENTS AND ADULTS

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SUICIDE INTERVENTION WITH
HEARING-IMPAIRED ADOLESCENTS

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Tne subject of adolescent suicide has been thoroughly
covered in the general mental health literature, but little
is available related specifically to the subject of ado-
lescent suicide in the deaf pop lation. A review of the
general literature is provided, highlighting those areas in
which particular application may be made in dealing with
hearing-impaired adolescents. A summary is presented of
unique dynamics and factors which apply to hearing-impaired
adolescen*s, and which helping professionals should keep in
mind in working with severely depressed adolescents. A
survey of programs serving hearing-impaired adolescents was
conducted, and results indicate that deaf youth are closely
following the trends in the general population in terms of
the numbers and severity of suicidal incidents. Particular
attention is given to factors and conditions which are
unique among deaf adolescents. A model for interventions
is offered, with specific techniques which may be used in
dealing with suicidal adolescents who are deaf. The model
developed at the California School for the Deaf in Fremont
is presented as an example of an intervention method which
is successful in providing both crisis management and on-
go' ig therapy for this population of young people.

For the purposes of this paper, suicidal behavior is defined as including
any self-abusive act or verbalization of suicidal intent.

Adolescence is a period of transition. It involves the process of letting
go of one stage of life, that of childhood, and entering the next stage--

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adulthood. One of the primary tasks of adolescence is separation--the entering of a "new life." When a child is born, parents pass through a time of intense pain. For the mother, this pain is much more physical, and for the father this pain tends to be more emotional and mental. If we can view the period of adolescence as the period of "birth into adulthood," we better understand some of the painful experiences through which both parents and teenagers pass.

For the adolescent, roles and expectations are often very unclear. Sometimes the young person is expected to assume adult roles and responsibilities, with such tasks as finding a part-time job, accepting more responsibility at home, or behaving with peers like "an adult." At other times the adolescent is treated very much like a child. Roberts (1975), in Self-Destructive Behavior states, "The individual becomes uncertain of the appropriate behavior expected of him/her and experiences a state of anomic normlessness, an unbridgeable gap between aspirations and achievements where individual passions are out of control" (p. 27).

An additional factor that enters in at this particular time of development is that of alienation. In the past, adolescents had an extensive support system consisting of relatively warm, caring families, stable school environments, and trusting adults. Today's teenagers, however, are maturing in a state of relative fear, facing experiences such as family breakups, overcrowded schools and uncertainties about the future and their role in it. They visualize an adult world that is often characterized as being abusive, non-caring, and in general undesirable. This alienation tends to breed a lack of trust within the child (Coals, 1983). Combine this societal sense of alienation with that which 's already inherent within the hearing-impaired child being reared by parents with whom he or she cannot communicate and in a world in which communication and language are essential to success by any measure--and the situation becomes even more threatening. (However, in some ways the lack of language experienced by hearing-impaired children may actually shield them from the flood of negative and frightening information with which the rest of society is constantly deluged).

The issue of locus of control, and the concomitant helplessness and hopelessness that characterizes the person who views his or her life as being controlled from an external locus, has been identified as a significant contributor to suicidal behavior in adolescents in general (Berkovitz, 1981; Davis, 1983).

A search of the literature revealed very comprehensive information regarding adolescent suicide in general, but none concerning suicidal behavior among deaf adolescents. The aim of our work is intervention with deaf adolescents experiencing suicidal concerns. It is felt to be reasonable that the same factors which differentiate deaf youngsters from their hearing peers in other areas of behavior (communication and linguistic impairments, socialization deficits, isolation within their homes and communities, frequent separation from family for educational purposes) might likewise impact upon the tendency of these young people towards self-injurious actions.

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CAUSAL FACTORS IN ADOLESCENT SUICIDE

The most commonly observed characteristic in suicidal youth is intense depression. Depression can be manifest in many ways including mood swings, sleep disturbances, fatigue and loss of energy, changes in appetite, decline in academic performance, and withdrawal from peers and extracurricular activities (Glaser, 1967; Petzel and Riddle, 1981).

Another frequently observed characteristic in suicidal youth is that of the "loner." During adolescence, the establishment and maintenance of significant friendships, both with members of the same and opposite sex is critical for normal development. Those young people who fail to develop significant close relationships often demonstrate signs of suicidal behavior (Madison, 1978). The implication for a hearing-impaired adolescent is clear. If the deaf youngster lives in an environment in which he is unable to participate freely due to a communication difficulty, his potential for developing loneliness and isolation is very great. A critical requirement for a hearing-impaired youth is to develop and maintain friendships, particularly in groups where they participate as equal members and not as "special" persons. A hearing-impaired peer group becomes, therefore, very important.

Alcohol and drug abuse have also been identified as significant factors in teenage suicide. Substance abuse is often used as a defense mechanism to combat depression. While such substances do not inevitably lead to suicide, they have the effect of leading to a loss of control over suicidal impulses (Dorpat, 1975). A number of destructive behaviors are also evident during the adolescent years, such as repeatedly driving while intoxicated, heavy alcohol and drug abuse, and willful disregard for safety factors (Sartore, 1976; Nielsen, 1983). These activities can be considered, marginally suicidal, although death resulting from them is seldom classified as such.

A lack of significant communication within the family has been repeatedly identified as a factor in suicidal ideation (Houseman, 1981). Particularly, a lack of empathic communication between mother and daughter has been shown to lead to suicidal conduct. Again, the implications for hearing-impaired children are obvious.

Stress continues to be a dominant characteristic of today's youth. High expectations and striving for excellence in school, athletics, or extracurricular areas may create an unusual amount of stress. These pressures, sometimes coupled with unrecognized learning disabilities may also be a factors in a significant percentage of adolescent suicide attempts (Kenney, 1979).

Family factors also play an important part in adolescent suicidal behavior. The American family has been in a state of radical change during the past 25-30 years. Families split apart by divorce, single parent families and/or female-headed households are becoming very common. Family disruptions and disintegrations play a significant part in teenage suicide. Lit, Cuskey, and Rudd (1983) noted that in 43% of cases reviewed, a family argument occurred prior to a suicide attempt. In those families where the possibility of divorce or separation was openly discussed, there was found to be significantly higher rate of teenage suicide attempts.

New parenting styles In use with growing frequency are changing old pat-
terns of child rearing. The trend toward devaluation of the family together
with an increased absence of Intimacy and affection, has been identified as a
significant causal factor In many instances of suicidal conduct. Institu-
tional environments In particular have been shown to have a chronic and
lasting influence on the children reared therein. It is critical for residen-
tial school programs to provide the most supportive and intimate environment
possible, for their hearing-impaired children. Based on this brief literature
review, a summative listing the causal factors which may impact on the ten-
dency of deaf adolescents towards self-injurious actions is included In Table
1.

TABLE 1

Suicidai Factors Which May Be Related to Deafness

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1.   Acceptance of self; self-image.
2.   Separation (parent and child).
3.   Unclear roles and expectations; few role models.
4.   Alienation from family and peers.
5.   External locus of control.
6.   "Loner" adolescent; rejected by peers and significant adults.
7.   Institutional environment; need for Intimacy.
8.   Lack of support systems (family, church, groups).
9.   Family disruptions, breakups, single-parent families.
10. Lack of communication, especially between mother and daughter.

STATISTICAL TRENDS

Currently, suicide Is rated second--tied with homicide--among leading
causes of death during the adolescent years. Only accidents cause more deaths
In this population group. More startling than this fact, however, Is the dra-
matic Increase In adolescent suicide over the past 30 years. Between 1960 and
1980, the suicide rate rose from 5.2 to 12.3 per hundred thousand In this age
group, representing a 136% Increase (Burman 1984).

A note of qualification needs to be made when quoting suicide figures In
the adolscent population. A large number of suicides may not be reported, and
It is unclear how many deaths that are labeled as accidents or homicides are
In fact a result of self-abusive behavior In adolescents. Law enforcement
agencies have reported that p_rental pressure for confidentiality often affect
what is recorded In cases of suicidal adolescent death (Porkorny, 1975).

While suicide-related deaths are a significant statistic, It has been
reported that for every completed suicide there are between 50 and 150 suicide
attempts (McIntire, Angel, Wickoff, & Schlicht, 1977). Indeed, one of the
frequent antecedents of a completed suicide Is previous suicidal behavior.

Girls are involved In suicide-related behavior far more frequently than
boys; however, boys are far more likely to be successful In their suicide

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attempts.   Reasons for this may be numerous, but the methods employed are a significant factor. Girls more often use methods that are likely to result in intercession by a third party, such as overdosing on pills and wrist slashing. Boys tend to use much fatal means, such as guns, ropes, or automobiles.

To provide a base from which to examine the issue of suicidal and self-abusive behavior among deaf adolescents, a survey of schools and programs for deaf students was undertaken.   One hundred fifty-three questionnaires were sent to programs through out the country.   These programs fell into two main categories:

1. Any pre-college program having at least 100 deaf students, at least some of whom were high school students.

2. A geographically balanced selection of larger postsecondary programs for deaf students.

Initially, a total of 92 survey questionnaires were returned (61%), of which 45% came from "deaf only programs," 31% from combined deaf/hearing (secondary) programs, and 24% from postsecondary programs.   A total of 12,130 hearing-impaired students are served in the programs that responded, of which 8,020 were of junior high school age or above.   Approximately 30% of these students were mainstreamed for at least part of the school day.   Forty-five percent of the students were residential and 55% were day students.

Preliminary results of the survey indicate that suicidal behavior is indeed a concern among programs serving deaf students.   Table 2 indicates that within the past twelve months, 134 of the students (1.7%) had made a suicidal attempt or gesture.   Three hundred of the students (3.7%) had verbalized suicidal ideation to another person.   Sixty-nine of the students (.86%) had been hospitalized during the past year for a suicidal or depressive episode. Within the data reported to us, no completed suicides occurred within the past twelve months.

A more in-depth treatment of these data will be presented in a subsequent article, once the final tabulations are completed.   The interested reader is directed to future publications on this topic.

The major finding of this study is that educators consider suicidal behavior among hearing-impaired students to be a significant concern.   Taking all reported forms of this behavior together, a total of 503 incidents of such behavior were noted among the 8,020 students included in this study, representing the past year alone.

Sixty-two of the 92 programs (68%) reported having no established policy for dealing with suicidal behavior among students.   Less than one-quarter (21%) repo' ed an established policy (not necessarily written) to guide intervention with suicidal students.

ADDRESSING SUICIDAL BEHAVIOR IN ¯HE SCHOOL SETTING

The first step in resolving a problem is the acknowledgement that a problem exists. A recent newspaper article compared the responses between two

TABLE 2

Number of Suicide-Related Incidents Reported

	DEAF STUDENTS ONLY n=41 Programs 4725 Students	COMBINED DEAF/HEARING n=28 Programs 1818 Students	POST SECONDARY n=23 Programs 1452 Students	TOTAL n=92 7995
ATTEMPTS/ GESTURES	102	16	16	134
VERBALIZE	216	49	35	300
HOSPITALIZE	48	11	10	69
STAFF EXPERIENCE (x=2.5)	2.54	1.91	2.48	2.33
STAFF TRAINING (x=2.5)	2.51	2.34	2.48	2.45

high schools following suicides among their students. At one of the schools, the administration chose to ignore and even cover up the fact that a student had committed suicide. This school experienced three more suicides among its student population within a period of six months. At the other school, where an immediate suicide awareness and prevention program was initiated in cooperation with mental health professionals, the single suicide was an isolated event; no ad'itional suicides occurred within a three-year period.

Today there are great pressures, particularly on residential schools and programs for deaf students, to project and maintain the most posi+ive public image possible. Indeed, every negative aspect of these programs seems to be scrutinized and openly displayed in the news media. Consequently, administrators may be tempted to hide problems from the public limelight, in an attempt to portray the most positive image poss ble to parents, legislators, and to the community as a whole. Nevertheless, research has demonstrated that where problems are overlooked or concealed, they tend to recur with increasing frequency and severity.

Curricula need to be developed to address the needs of three specific groups--adolescents, parents, and professionals as they relate to suicidal conduct among hearing-impaired adolescents. Each group has its own particular needs, concerns, and point of view. Programs need to deal with the issues of

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prevention techniques, coping skills, and communication development. Additionally, professionals, parents, and peers need to be alerted to the danger signs that nearly always appear prior to suicidal conduct in adolescents.

The intervention program in use at the California School for the Deaf in Fremont is described in the following sections of this paper.

CSDF SUICIDE INTERVENTION MODEL

The suicide intervention model described in this section has evolved from and continues to be modified by experiences with suicidal students at the California School for the Deaf at Fremont (CSDF). Current practices and continuing efforts to upgrade the quality of suicide intervention at CSDF are presented below in three sections: the system--intervention by the school and community; screening suicide potential--including a diagnostic checklist for use by clinical staff; and longer term treatment.

THE SYSTEM

Effective suicide intervention in an educational setting must involve the whole school. It depends on the staff's ability to recognize and respond appropriately to suicidal behavior. Cottage, school and health service staff are often the first to detect suicidal behavior. Everyone in the system is important, but particularly critical are the residential staff who are in direct contact with the students after school hours.

Residential and health service staff must know how to interact with students who display suicidal behavior, be comfortable talking openly with students about suicide, and know how to initiate hospitalization in emergencies. All staff need to be able to recognize warning signs and to know how and where to refer students for further assistance.

Students, too, are a part of the system. Adolescents striving for independence often confide more in friends than in parents or school staff. Peers need to be encouraged to inform adults when they know of a friend who might be suicidal. The suicide note in Figure 1 was written by a student to other girls in her cottage. Fortunately, the students understood what the girl was trying to say and passed the note to the cottage counselors, who in turn referred the girl to a guidance counselor.

FIGURE 1

Suicide Note from a Residential School Student

Dear Girls,

I will be bird (white) in Heaven God and peaceful I miss you youre are friend so long. I know you care of me so long time.

Goodbye

Class of '87

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When suicidal behavior is observed, the case is referred to the Counseling Department. Details on the guidance counselor's intervention with suicidal students is covered in the section entitled "Suicide Potential Screening". In addition to working individually with students, counselors also consult on cases to assist staff and outside agencies; and assist in training of "nonclinical" staff.

In a training guide and videotape developed at CSDF to help train "nonclinical" staff in responding to suicidal students, Pollard (1986) stresses involvement, listening and networking.

Involve Yourself. Staff are taught that their training has given them skills to save lives; that they are qualified to discuss the topic of suicide and cannot inadvertently "give someone the idea" to suicide. Many times it's a relief to the suicidal student to have his concerns out in the open. Suicide loses some of its power when it's no longer a secret.

Listen, really listen. Staff try to get as much information from the student as possible. It is helpful to discuss problems, feelings of hopefulness, and the suicide plan itself. This information is vital to mental health workers who become involved later on.

Networking. Every support and resource person who is mobilized for the suicidal person offers one more level of help and safety to benefit the student. Family, friends, staff, and professional mental health workers are fully informed. Suicidal ideas are not secrets worth keeping!

The "decision tree" in Figure 2 outlines procedures and steps the residential staff are trained to take when suicidal behavior is noticed. Under the intervention stage of the decision tree are six areas that include some common signs of suicide. Details about stress, history, the plan, and resources are included in the section entitled "Screening Suicide Potential." The staff are also trained to note specific verbal and behavioral signs.

Verbal signs of suicidal intent include direct threats as well as more vague "disguised" statements. Less direct verbal signs are statements like "I won't be around much longer." "Someday you'll be sorry about this," or "I'd be better off dead." Any threat of suicide should be considered a serious warning sign. The staff should not try to decide if the student "really means it."

Behavioral signs include indications of depression such as sadness, sleep or eating problems, crying, social withdrawal and mood swings. A more obvious wa ning sign would be giving away favorite things to friends. Drug or alcohol us always increases the level of dangerousness.

The local hospital is also an important part of the system. The hospital used by CSDF has a well earned reputation for good medical care; and the people on the "pscyh ward" are well qualified, but they have little experience with deaf people. There are still problems when a student is kept for more

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FIGURE 2

Decision Tree Outlining Procedures for School Staff to take When Suicidal Behavior is Noted

Phone Numbers:

Supervisor: _____   Health Svcs.: __x3747__   Emergency: __911__

Dean: _____   Suicide Hot Line: __794-5211 V/TDD__

Suicide Decision Tree

```
                    Observe Behavior
                    Interact/Converse

                      Are Self-
         No ←────    Harming Ideas
                      Suspected?
                         Yes  *

  Consider Counseling      Converse About Problems
      Referral                   and Suicide,
                          Remember 6 Important Areas
  Consult Supervisor
       Soon                   Are Suicide
                              Ideas Present
              No ←────        Or is Non-verbal
                              Evidence Present
                                    ?
                                   Yes

                            Contact Supervisor
                               Immediately

                              Probe  ────→
```

Monitoring — **Investigation** — **Intervention (With Supervisor)**

Box (right side):
```
            *
         Always
  - Involve Yourself
  - Listen
  - Involve Others
```

6 Important Areas

- Verbalizations
- Behavioral Signs
- Stressors
- Past History
- Suicide Plan
- Resources

```
                    What Is
                  The Level Of
                  Dangerousness
                       ?

     Low            Medium             High
```

(Harm not imminent or likely soon)	(Harm is possible but not imminent)	(Harm is likely or imminent)
Monitor More Often	Monitor Hourly	Begin Emergency Procedures As Needed → #911 → 1st Aid
Make Counselling Referral	Consult Others As Needed: Health Svc, Dean, or Suicide Hot Line	Contact Health Svcs.
Consult Others As Needed: Health Svcs, Dean, or Suicide Hot Line	Document Probe Info.	Consult Counselors, Dean, or Others As Needed
Cooperate With Follow-up Work	Make Counselling Referral	Document Probe Information
	Cooperate With Follow-up Work	Make Counselling Referral
		Cooperate With Follow-up Work

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than a few hours, as the hospital must then take responsibility for inter-
preting services. The guidance counselor should not have to ~t as an
interpreter. Instead s/he can help coordinate or provide follow-up treatment
upon release. Additionally, as they serve as an intervention resource, the
awareness of the hospital administration and staff continues to increase.

An alternative to hospitalization is the use of the CSDF Health Services
Facility. It serves as a quiet place for the student to stay, under close
supervision, during short-term crisis periods.

A final comment about the system. Schools cannot be all things to all
people but they can strive for an atmosphere focused on preventive mental
health. At CSDF, paticipation is encouraged in extracurricular and community
activities as a deterrent to withdrawal and isolation. An attempt is made to
build involvement and commitment to society. For example, the involvement of
some students in the Statue of Liberty fund-raising seemed to add a sense of
value to their lives. Too often programs for deaf students "do for"
youngsters, rather than teaching students to "do with" others.

The next section explores more in-depth what happens after referral is
made to the guidance counselor(s).

SUICIDE POTENTIAL SCREENING

The checklist included in Appendix A was designed to assist the guidance
counselor when evaluating a student referred for suicidal behavior. It serves
four basic functions:

1. To evaluate current lethality
2. To guide crisis intervention
3. To act as a catalyst for the beginning of a therapeutic process
4. To guide follow-up treatment

No scale can really measure suicidal risk, and it would be dangerous to
expect a concluding judgment from this or any other diagnostic screening
device. Since lethality is a subjective judgment, individual items on the
checklist are not given numerical weight. This checklist does however, help
the clinician focus on the areas that are known to contribute to suicidal
risk. Age statistics are not included because it is designed specifically for
CSDF's adolescent population, nor is sex of the student requested on the form
although gender differences exist in suicidal behavior.

Guidelines for using the checklist are presented below in order to
describe the different parts of the Suicide Potential Screening checklist and
how to complete it. It can be filled out with the client or it can be studied
before and filled out as a follow-up to a counseling session.

The "Primary Case Manager" designation, listed at the top of the form, is
usually the counselor but sometimes is an outside professional. Most often
the person filling out the checklist ("the Evaluator") is the primary case
manager. Description of behavior that precipitated the referral should be
brief and to the point, hence only limited space is provided. Examples from

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our files include the following: "attached note was given to . . ." or "counselor overheard student tell her friend she wanted to die" or "found scratch marks on arm near wrist. When asked, the student said he was trying to kill himself." Figure 3 represents a note that prompted a referral to a guidance counselor at CSDF. Discussing this precipitating behavior with the suicidal student is often a good way to start the interview, for example, "I want to talk to you because you told John you wanted to kill yourself."

FIGURE 3

Suicide Note From a Residential School Student

November 20, 1985

Dear J_____,

I think that I am boring person. I wish my mother can come here and visit me. Because she did not coming here for many times. She went here for once times. All of my life, It is my fault everything all the time. Please tell me when is your birthday? I always have alot bad mood. I should be change this way. But maybe will not be happy. If unless my mother is doing find and happy. So I will be very happy with her. I am beginning give up myself. Because I would not eager by not. Sometimes night I am crying. Because my mind is still bothering about something. When you are leaving her and I am feeling want more close with you. You are very wonderful. Last night I was trying to take medicine and shallow it.

Love,

Affirmative answers indicate a higher risk except for the last category (e.g., V. SUPPORT SYSTEM). A "yes" to that category means that the student feels some support and usually includes a reduced risk of suicide. Even indeterminant responses on the checklist provide valuable information, since they would indicate what additional information is needed about the case before treatment decisions can be made:

I. The Plan: The suicide plan is critical in determining current lethality. Get details about the students' suicidal ideas. Does he have a plan to kill himself or does he just think about "being dead?" The presence of a plan signals greater danger. If there is a plan, what are the details? How will the student kill himself—jumping, pills, a knife, a gun, starvation? Think about how "dangerous" his plans is, and if he has access to the materials he plans to use. Answers to these questions signal the difference between an acute emergency that requires immediate action, and a less dangerous situation that allows for ongoing counseling. The more dangerous (lethal) the method and the more easily it can be accomplished, the more quickly one must act. One of the first questions the evaluator should ask is "If you kill yourself, how will you do it? When? Where?" A student may not initially disclose this information, but willingness to talk openly about it

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can help. It is a myth that suicide ideas can be planted in a person's mind. Talk openly about death and dying, and what it means to the student.

After the question, "Verbalization of suicide ideas?" (number 4), there is space to note down the student's verbalized suicidal ideas. This question can initiate a discussion about the realistic aspects of the student's suicidal fantasies. For example, youngsters frequently carry the mistaken notion that they will be able to see, feel and react to people after completing a suicide.

II. **Stress**: Sometimes no plan exists, or the plan considered is neither dangerous nor realistic. The episode may, however, signal an elevated level of stress in the youngster's life. Young people suffer a great deal of stress which can lead to suicidal intent. Besides the stress of just growing up, other stressors to watch for are: parental divorce, breakup with a boyfriend or girlfriend, academic failure, peer relationship problems or rejection, ph..ical problems, deaths of friends or family, transfer to a new school, friends transferring or graduating, and increased responsibilities such as a school play, sports, or graduation.

If stress is great but the student is not otherwise at risk, then shorter term counseling, problem solving sessions, or some help with decision making skills may be a sufficient intervention. Because of the suicidal question there may be tendency to forget good clinical judgment and try to solve a student's stress without first finding out where he is coming from, what he has tried, and how he preceives his situation.

III. **Signs of Depression**: This form is not designed to make a formal (DSM III) diagnosis of depression nor does it ask if such a diagnosis has been made. The questions here are designed to indicate if enough depression exists to prompt concern.

Adolescent cries for help often appear in the form of rebellion. If that rebellion does not succeed, withdrawal often follows. Ineffective symbolic withdrawal may give way to physical withdrawal such as running away or suicide. The symptomatic progression of rebelling, withdrawing, and running away is a significant indicator of suicidal risk. Therefore question #25, "Has there been a progression of #33, 34, 35?" is asked.

IV. **History**: Historical factors can add to suicide risk in a variety of ways. Issues such as lack of acceptance of deafness, family difficulties, and additional disabilities compound the treatment needs of suicidal students and may dictate a different course of therapy. Particularly potent in our experience is the issue of learning disabilities (L.D.). Often the educational program for deaf students focuses only on the deafness and the L.D. problem can "slip through the cracks" or be ignored. Learning disabilities are stressful enough. When compounded with deafness, they may become even more stressful if they are not addressed.

Items which add significantly to suicide risk in the adolescent's history are #27, "Previous suicide attempt", #28, "Previous suicide threats/verbalizations", and a combination of #35, "Long history of problems," and #36, "Recent period of escalation of problems". The more frequently someone

attempts or plans suicide, the more likely it is that they will someday "succeed."

V. <u>Support Systems</u>: The key here is to assess support systems from the student's point of view. This helps both to determine present danger and to identify potential sources of support that may already exist but are not perceived as such by the student. It is not enough to determine that the student at the present time will not kill himself. The counselor and student must also mobilize resources to reduce the threat of future suicide and to replace suicide as an escape method with other coping skills.

Even when a student is hospitalized, he routinely returns to school at some later date, thereby requiring supports to be in place to help him back to normal functioning. Generally, the more supports a student has (caring family, counselors, teachers, close friends, teammates, relatives, club members, etc.) the better are his or her chances of coming through a crisis successfully. To be helpful, however, these resources must be identified and used.

VI. <u>Plan of Action</u>: The purpose of the plan of action is to formalize the next steps to be taken by the student and the evaluator and to make sure that the commitment fits the seriousness of the situation.

The more serious the risk, the more immediate and concrete is the commitment required. Often this takes the form of a contract between the evaluator and student. Some examples are:

" I promise not to hurt myself before our appointment tomorrow at one o'clock." Sign and date.

"If I feel like hurting myself I promise I will talk to you first before doing anything." Sign and date.

"I will talk to my cottage counselor tonight at (a potentially lonely time)." Sign and date.

One student at CSDF was ready to jump off a high wall when his counselor reminded him of his contract not to hurt himself. He immediately got down and said, "Sorry, I forgot about that." Not all cases are that easy, but it is not uncommon for the contract—the promise—to become more important than the student's own life.

Another technique that worked with a higher functioning student who had a good sense of caring for other children is as follows. She had been a parentified child and all her sense of worth was caring for others, but life was not worth living for herself and she was a high suicide risk. The counselor described a little girl to her in detail, as he imagined the student to have been as a little girl. He then asked if she would not do him a big favor and take care of that girl for one day because harm might come to that little girl since she was not able to protect herself at this time. The counselor needed a reliable babysitter and wanted her to do it for him. She promised she would do a good job! Then he named the girl (the real girl's name) and had her

Imagine opening herself up and letting the little girl crawl inside of her. Not all deaf students can imagine as abstractly, but sign language helps make it a vivid picture. She did not try to hurt herself at that time (as she had in the past), and the little girl inside was referred to often in future therapy sessions.

Once in a while a student needs to be hospitalized. Hospitalization can be a constructive experience since it teaches that life is not to be casually jeopardized and that threats will be taken seriously. In our experience this lesson has outweighed the potential problem of "rewarding" a student with attention for his suicidal behavior. Given the choice, we'd prefer to hosiptalize a student "too soon," than to err and hospitalize too late.

At its end, the suicide screening form asks for parent contact, a critical component sometimes forgotten in school settings if the student is not a behavior problem. It also requires colleague review. Such review is not for supervisory purposes. Rather, it involves another professional in the case so the suicide burden is shared and professional decisions enhanced.

LONGER TERM TREATMENT

Therapeutic treatment of the suicidal deaf adolescent often begins in times of crisis. Once the crisis has subsided, longer term treatment must be considered.

The therapeutic process might proceed through the following overlapping phases (Motto, 1985):

   I. Establish a relationship. It should be dependency-tolerant and non-threatening.

  II. Stimulate emotional growth. Encourage self-sufficiency without stirring fears of abandonment.

 III. Diminish dependency gradually, at a pace consistent with the young person's maturation.

"The most important tool in the prevention of suicide is the establishment of a meaningful relationship . . . " (Wesseluis, 1973). Human connections save lives. The therapist can be a life line to the client, but he needs to be willing to be involved and to make a commitment. If the therapist cannot make the commitment, a referral should be made.

As the therapist begins to build a post-crisis relationship s/he should deal with the student's stress by focusing on the specific current problems, and try to determine how serious the problems are felt. For example, a "C" versus an "A" in math may be serious matter to a high achieving student.

Attending skills become more critical with a suicidal client:

    - Show warmth.
    - Be genuine and vulnerable.

- Maintain eye contact (except perhaps for Asians).
- Maintain a low, respectable non-threatening posture.

At the same time it is equally critical to have ethical strength:

- Know your limits.
- Be direct--straightforward.
- Require respectful treatment.
- Don't be blackmailed; that is don't be manipulated by threats of suicide.
- Never make a promise you can't keep, for example, "Don't worry, you'll get better grades." Resassurance is phony, since the student knows everything is not okay.

The next objective of the therapist is to stimulate emotional growth in the adolescent. Deaf children often lack the validating self-growth experiences important to normal development. Compounding this low self-image in suicidal youth is a sense of hopelessness.

The counselor/therapist needs to keep in mind that a person's self-concept is hard to change, especially when the student's response to a therapist's positive feedback is the inner reaction: "If you really knew me you'd know I'm a lousy person." The counselor must deal with the client's disbelief in himself by helping him gain internal control over his life and master the external things he is able to control.

Adolscents cannot tell the difference between themselves and their problems. By externalizing the problems and clarifying the difference between facts and emotions, the therapist can separate the problem from the person.

As the therapist is stimulating emotional growth he needs to start incorporating the last objective--to diminish dependency and gradually instill control within the student. The student must be encouraged to develop coping and decision-making skills, and begin to accept responsibility at a level fitting his skills. Role-playing situations such as dealing with teasing from other students can be helpful. The focus should be on attempts, not outcomes. "You did ignore his tease. Great! You handled it fantastically even though he kept teasing you."

Overprotection often occurs with disabled children, making the separation-individuation process more difficult. The therapist can help clarify roles and expectations by encouraging the natural adolescent/parent separation. By looking for the love and caring in familial relationships, he can help both parents and student to express it. If the family is too resistant to change, then he must help the adolescent accept things as they are and focus on those areas the adolescent can change in himself.

Suicidal behavior is a cry for help, yet there is a segment of this population that resists treatment. It may be from lack of trust of adults or anyone--whatever the reason, one should reach out. One such student refused to come for counseling but showed many of the warning signs of suicide. After numerous rejections of staff offers of help the guidance counselor finally

sent the letter shown In Figure 4. It later came out the student had made serious plans to kill herself and had followed her mother's request not to go to counseling for fear of family secrets being exposed (which included physical abuse).

Finally and critically, the therapist must take care of himself. If his stress level causes him to become ineffective, he could be dangerous. A competent, confident manner by the herapist In dealing with a suicidal student will promote similar feelings In the student. On the other hand, a depressed therapist can be lethal!

Countertransference can be strong and a therapist needs to know when It occurs. His own denial of death or feelings about death can easily surface when working with a suicidal student. The counselor needs his own support system too.

SUMMARY

The deaf suicidal adolescent has been discussed from several different perspectives. Statistical trends In suicidal behavior, causal factors of suicide that may apply more significantly to the deaf population, and a pilot study of educational programs serving deaf students have been described. Finally, the suicide intervention model at CSDF has been described.

The CSDF Intervention model Included systemic interventions, a diagnostic checklist for screening suicide potential, and longer term treatment. The system components Included the school staff--guidance counselors, cottage counselors, health service staff, teachers and administrators; students; and community agencies. Successful Intervention Involves networking and developing awareness of warning signs of suicide.

A tool for preliminary assesment of suicide risk Is offered. It Is specifically designed for the guidance counselor to evaluate current lethality, to guide crisis Intervention, to act as a catalyst for the beginning of a theraputic process, and to guide follow-up treatment.

Suicidal thoughts continue after the crisis Is over. Longer term treatment of the suicidal deaf adolescent Is basically the same as for other troubled young people. Mentioned here were concepts considered good clinical practice that particularly apply to this population. One such concept used by Rusk (1985) In training therapists to deal with suicidal clients fits as a summary:

- Common sense counts alot.
- Reward any change In positive direction.
- If hostility and anxiety and detachment decrease - Continue.
- If hostility and anxiety and detachment continue or Increase,

THEN BACK OFF AND GET LOTS OF HELP!!!!!!

FIGURE 4

STATE OF CALIFORNIA
DEPARTMENT OF EDUCATION

CALIFORNIA SCHOOL FOR THE DEAF

39350 GALLAUDET DRIVE

FREMONT, CALIFORNIA 94538

TELEPHONE (415) 794-3666

HENRY KLOPPING
SUPERINTENDENT

October 21, 1985

Dear

I respect that you do not want to come and see me right now.   But I am concerned that you find ways to protect yourself.

You are welcome to come back any time.   If you want to see me for any reason I will be happy to talk with you.

But even if you decide not to come for counseling, it is important that we close appropriately, that we stop counseling the right way and meet one more time to "wrap things up" – to summarize some of the important things we have talked about.

I have scheduled you for 9:15 A.M. on Wednesday morning

Leave me a note if you need to come at a different time.   If no note, I'll see you at 9:15 A.M. on Wednesday.

Sincerely,

Fred Morrison

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California School for the Deaf, Fremont
Suicide Potential Screening

Student_____Date_____Evaluator_____

Primary Case Manager_____Referral From_____

Description of behavior that precipitated referral:_____

_____

YES ? NO   I.   **PLAN**
___ ___ ___   1) Is there a plan?
___ ___ ___   2) Is it specific? How? Where? When?_____

_____
___ ___ ___   3) Are the means available?
___ ___ ___   4) Verbalization of suicide ideas?_____

_____
___ ___ ___   5) Tying up loose ends or giving away important items.

6) Estimated danger of the PLAN   Low----------------------HIGH

                                II. **STRESS**
___ ___ ___   7) Death or loss of important person.
___ ___ ___   8) Girl/boy friend break-up.
___ ___ ___   9) School pressures.
___ ___ ___   10) Extreme parent/child conflict.
___ ___ ___   11) Use of alcohol or drugs.
___ ___ ___   12) Agitation.
___ ___ ___   13) Other_____

14) Estimated amount of STRESS   Low---------------------HIGH

                          III. **SIGNS OF DEPRESSION**
___ ___ ___   15) Despondent.
___ ___ ___   16) Deflated self-image,
___ ___ ___   17) Problems internalized, self-blaming.
___ ___ ___   18) Changes in eating or sleeping habits (eating disorder?)
___ ___ ___   19) Unwilling to communicate.
___ ___ ___   20) Neglect of personal appearance.
___ ___ ___   21) Neglect of school work.
___ ___ ___   22) Sexual acting out or rebellious behavior.
___ ___ ___   23) Withdrawn.
___ ___ ___   24) Truancy or running away.
___ ___ ___   25) Has there been a progression of #33, 34, 35?

26) Estimated degree of DEPRESSION   Low---------------------HIGH

                              IV. **HISTORY**
___ ___ ___   27) Previous suicide attempts.
___ ___ ___   28) Previous suicide threats/verbalizations.
___ ___ ___   29) Disorganized family life.
___ ___ ___   30) Suicide behavior in family or relatives.
___ ___ ___   31) Has trouble coping with hearing impairment.
___ ___ ___   32) Low impulse control or poor judgment.
___ ___ ___   33) Learning Disability
___ ___ ___   34) Other chronic diseases or deformity.
___ ___ ___   35) Long history of problems.
___ ___ ___   36) Recent period of escalation of problems.

37) Increase in risk based on HISTORY   Low------------------HIGH

V. SUPPORT SYSTEM

<u>YES</u> <u>?</u> <u>NO</u>   Does the student feel support from the following?

___ ___ ___   38) Primary case manager_____

___ ___ ___   39) Guidance Counselor or Therapist_____

___ ___ ___   40) Parents_____

___ ___ ___   41) Cottage Counselor(s)_____

___ ___ ___   42) Teacher(s)_____

___ ___ ___   43) Friends_____

___ ___ ___   44) Club or teammates_____

___ ___ ___   45) Clergy or church members_____

___ ___ ___   46) Other_____

47) Name the above who could be supportive.
48) Strength of SUPPORT SYSTEM   Strong------------------Weak

49) CURRENT ESTIMATED LETHALITY   Low------------------HIGH
                                                     (Hospitalize)

VI. CONCLUSIONS/PLAN OF ACTION

_____

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ASSESSING THE SELF-IMAGE OF
DEAF ADOLESCENTS

MICHAEL C. ACREE

Two long-term longitudinal studies yielded validity
and reliability data on a revised version of the Tennessee
Self-Concept Scale for the deaf (TSCS-R) and on the Meadow
Pictorial Scale of Self-Image (MPSSI). The TSCS-R was sup-
ported in conventional terms. The MPSSI was found to be
uncorrelated with other measures, except for parental
ratings on the Meadow-Kendall. Despite such apparently
strong evidence against its validity, this paper suggests
that the MPSSI may indeed be valid, but that the relation-
ships between self-image and other variables, such as aca-
demic achievement, ordinarily adduced for validation, are
more complex (nonlinear) than usually supposed.

This paper reports on two measures of self-image developed specifically
for deaf persons--one for children and adolescents, the other for adolescents
and adults--which have been used in two long-term longitudinal research pro-
jects at the UCSF Center on Deafness. The first measure was designed by
Kathryn Meadow (1967) for use in her now-classic dissertation research, which
examined, among other things, the relation of self-image to parental hearing
status. This instrument was used again in another study (Study II to be
reported here), which was the fifth round of a developmental investigation of
a group of 40 pre:ingually deaf youngsters, adolescents at the time of this
testing. The second measure, a modification of the Tennessee Self-Concept
Scale (Fitts, 1965), was developed for longitudinal follow-up of participants
in Meadow's dissertation research (Study I to be reported below), now in young
adulthood. The two studies taken together, with their rich array of other
variables, provide an unusual opportunity for compiling data on the validity
and reliability of these two instruments.

STUDY I

Both Meadow's dissertation and the 12-year follow-up were very large projects, employing a large number of variables. The focus here will be restricted to hypotheses and measures of self-image, which was a major variable in both rounds. It was hypothesized in Round 1 that deaf children of deaf parents would score higher on self-image (among many other variables) than deaf children of hearing parents. The second round was designed to investigate the long-term stability of such differences.

Subjects

Selection of subjects for Meadow's (1967) dissertation research (Round 1) was guided by her hypotheses, in which hearing status of parents was the chief independent variable. The 58 children of deaf parents at the California School for the Deaf in Berkeley who agreed to participate in the study were matched with children of hearing parents, from the same school, in terms of sex, age, and residual hearing, and approximately in terms of family climate (including family size) and IQ. Children of hearing parents were excluded if they had deaf siblings, the obvious reason being that communication modes between deaf siblings would render them more like the children of deaf parents. Racial and ethnic minorities were excluded in order to reduce variance extraneous to the purpose of the study. Children with multiple disabilities, as well as those deafened by maternal rubella, Rh incompatibility, or birth anoxia were excluded for similar reasons, but also because of possible neurological damage which could be implicated in language development. All children had to have become deaf by the age of 2, and to have a hearing loss of at least 58 dB--80% of them actually having a loss in excess of 80 dB.

For the 12-year follow-up (Round 2), 43 of the original 116 either could not be located or never responded, 8 refused to participate, 1 was living outside the U.S., and 2 had committed suicide. Owing presumably to the greater ease of locating them, offspring of deaf parents are somewhat overrepresented in the recapture sample--36 participating compared with 26 (from the original 58) children of hearing parents (chi square = 2.81, $p < .10$). As these students had proved superior on many measures in the original study, the follow-up group is correspondingly an above-average selection from the original group.

It should also be borne in mind that the original sample of 116 was not, nor was it intended to be, either a random or a representative sample of the genera' population of deaf people aged 5 to 21 (18 to 34 at the time of the follow-up): children of deaf parents were overrepresented by a factor of 5; and attrition increases that factor to 6 in the present sample of 62.

Measures

In all, four measures of self-image were used in this study, two in each round.

Round 1

Meadow Pictorial Scale of Self-Image. Children are presented a page with cartoons, one each for six dimensions: lazy, pretty or handsome, smart, nice, mean, silly. The cartoons show both the words and illustrations of the manual signs. Children are asked to rate themselves for each dimension on a five-point scale; e.g., "very, very nice," "very nice," "rather nice," "a little nice," "not nice." On succeeding pages they are asked to answer on the same scales "What does your mother think of you?" and so on for father, teacher, counselor (or principal), boys at school, girls at school, and hearing people.

> Separate forms of the test, showing pictures appropriate for both sexes, were made for boys and for girls. Instructions were signed and spoken simultaneously by persons proficient in manual communication. For junior and senior high school students, the tests were administered in groups of approximately twenty. For elementary students (ages approximately 9 through 12), the instrument was administered in groups of from five to ten children, with three persons assisting so that individual attention and supervision were possible. For the younger children (ages 6 through 8), administration was individual, each question being asked separately (Meadow, 1967, pp. 87-88).

The Self-Image Scale was scored by adding the 48 (6 adjectives x 8 appraisers) 5-point responses, so that the maximum possible score was 240. In the original sample the actual range was from 135 to 240.

Teacher-counselor ratings. Students were also rated on a battery of social and communicative variables by three (or, in a few cases, two) teachers or counselors who knew them well, comparing them on a 10-point scale with "all students in a certain grade or dorm group." The anchor descriptions provided by the scale of self-image were "has strong feelings of personal worth and importance" and "feels inferior; no feeling of being a worthwhile person."

Round 2

Revised Tennessee Self-Concept Scale. The Tennessee Self-Concept Scale (TSCS) (Fitts, 1965) was selected for this study, largely because it has been widely used with a variety of populations. At about the time the study was to begin, however, Garrison, Tesch, and DeCaro (1978) published a report casting doubt on the appropriateness of that instrument for deaf individuals. In using it with a sample of 87 entering students at the National Technical Institute for the Deaf, they obtained a test-retest reliability coefficient for the Total Positive score (the overall index of self-esteem derived from the test) of .77, as against a reliability coefficient of .92 for Fitts' normative sample. Suspecting comprehension problems, they trichotomized their sample on the basis of scores on the California Reading Comprehension Test, and found some support for their suspicion in the reliability coefficients of the upper and lower thirds: good readers ($N = 28$) had a coefficient of .82, poor readers a coefficient of .72. Results on subscales were generally consistent, though many differences were small, and there were some reversals (where the scores of poor readers were more reliable than those of good

readers). Interviews with the respondents fu.ther confirmed the impression that the deaf students had trouble understanding the test items.

As a result of these findings, the UC Center on Deafness undertook a major revision of the Tennessee. (Written permission was obtained from William H. Fitts, author of the TSCS, for modification of the scale for use with this one sample only.) Items difficult to render in sign language were modified or dropped, leaving 55 of the original 100 items. Items from one of the basic dimensions of self-concept, the Moral-Ethical Self scale, were dropped entirely. Selection was done in such a way, however, as to preserve an approximately equal number of items in the other dimensions (Physical Self, Personal Self, Family Self, and Social Self, as well as the orthogonal partition of Identi.y, Self-Satisfaction, and Behavior) as well as a balance of positive and negative items.

Several years later, Kim Gibson independently revised the TSCS for deaf persoñs (Gibson-Harman & Austin, 1985). She retained all 100 items, but feels that the rewording of some items, especially on the Moral-Ethical Self scale, is not fully satisfactory (personal communication, April, 1986). Her revision yielded a test-retest reliability of .76 with deaf persons.

Interviewer's Global Assessment of Self-Image. The TSCS was administered individually to participants as part of an interview, and the 'nterviewer/ interpreter helped as much as was necessary in assuring that the items were understood. For the estimate of stability the same questionnaires were mailed to participants about a month later, 50 of which were returned. It is not known how much help individuals may have had in this administration. For a crude estimate of validity, the interviewer also rated the self-esteem of each participant on a 1-to-5 scale. This rating was scarcely independent of scores on the Tennessee, however, since the interviewer had access to responses on that scale.

Results

Psychometric properties of the Revised Tennessee Self-Concept Scale. Shortening the TSCS by almost a half would be expected to reduce reliability from the .77 reported by Garrison, et al. (or Fitts' .92) to about .65 (or .86). It should be no:ed that these comparisons are only approximate, being based on different methods for estimating reliability: the Kuder-Richardson formula for reliability of a shortened form is based on internal consistency rather than retest stability; but the figures give a rough idea of the effect of shortening the test. The actual test-retest reliability obtained for this sample was .71, comparable to the figure of .76 obtained by Gibson (Gibson-Harman & Austin, 1985). Thus it would appear that any loss in reliability from decreasing the length of the test was offset by gains in comprehensibility of the revised version.

There is some evidence that the second testing yielded less coherent, less meaningful results than the first: the correlations of the second administration of the Tennessee with almost everything else were lower than those of the first. The evident implication is that conditions of the second administration made it less internally reliable, and that the present figure of .71

underestimates the test-retest reliability of the Revised Tennessee when administered with an interpreter.

The issue of reading comprehension was explored in several further sets of analyses. The results show some tendency--less consistent in the present sample than in that of Garrison et al.--for scores of better readers to show greater reliability. That reading ability makes a more consistent difference in reliability in the Garrison study can be interpreted as supporting the modifications made in the present version.

One other feature of the Self-Concept Scale is appropriate to mention among its psychometric properties: the evaluation of certain subscale scores relative to Fitts' normative sample. To facilitate comparisons, all data are presented in terms of individuals' means rather than sums. Table 1 shows, for the present sample, for Fitts' data, and for Garrison's, the means of the overall scale (which Fitts labels "Total Positive") and the various subscales. The ratio of true to false items endorsed is also included, as one remaining scale-value calculable from the reduced set of 55 items. As can be seen from the table, scores for the three samples are generally similar, except that lower scores are found among the deaf samples on the Self-Criticism scale and higher scores on the True/False Ratio. These differences are great enough to require comment. They are pointed up more sharply by percentile comparisons. Of the present sample, 95% fell below Fitts' median of 3.60 on the Self-Criticism scale; the highest score here was at his 60th percentile. On the True/False Ratio, 29 individuals (nearly half) fell above the 95th percentile of 1.40. For the second administration of the test, where respondents may not have had help, the figures are still more extreme. The True/False Ratio essentially measures agreement response set; and a strong agreement response set tends to lower the self-esteem score. The extreme elevation of the True/False Ratio in the deaf samples, particularly when an interpreter may not have been present, suggests a tendency to agree in the face of ambiguity. (Hearing persons who do not read sign language well are presumably displaying the same tendency when they find it easier to nod than to shake their heads in response to a message they fail to understand.)

Items on the Self-Criticism scale were taken from the L-Scale of the Minnesota Multiphasic Personality Inventory, with the direction of scoring changed: endorsement of an item (e.g., "I prefer to win than lose in a game") adds to the Self-Criticism score, whereas denial of the item raises the score on the L-Scale of the MMPI. Low scores on the Self-Criticism are thus seen as indications of defensiveness; and the overall self-esteem level is generally considered to be artificially elevated when Self-Criticism scores are low. In the present sample, however, that interpretation appears to be questionable. Whereas correlations of the other, content subscales with the Total Positive score range from .67 (Family) to .83 (Social) for this sample (.75 to .96 for Fitts'), the Self-Criticism scale correlates -.10 with Total Positive and the True/False Ratio -.28 (-.44 for the second administration). Hence it is not clear that only individuals low in self-criticism have inflated self-esteem scores--or else the true self-esteem level of these individuals is really low. Quite possibly it is those individuals who are low in self-esteem who read poorly, are confused by many items, and have the greatest tendency when confused to agree and try to look good. The True/False and Self-Criticism scales

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TABLE 1

Subscale Means of the Self-Concept Scale

Present Study

Subscale	First Administration	Second Administration	Garrison	Fitts
Total Positive	3.77	3.79	3.56	3.84
Personal	3.83	3.88	3.64	3.59
Physical	3.81	3.85	3./6	3.99
Family	3.85	3.85	3.54	3.94
Social	3.64	3.72	3.44	3.79
Self-Criticism	2.83	2.95	3.02	3.55
Identity	3.81	3.86	3.90	4.24
Acceptance	3.56	3.62	3.29	3.46
Behavior	3.60	3.66	3.48	3.83
T/F Ratio	1.44	1.47	1.57	1.03

thus appear to be especially important in interpreting scores on the Self-Concept Scale for the Deaf.

Relationships among measures of self-image. Correlations between the four measures of self-image in this study may be arranged in the matrix shown in Table 2. The structure of the table recalls Campbell and Fiske's (1959) multitrait-multimethod matrix, if self-image in adolescence and adulthood be considered separate traits (they should indeed be less highly correlated than contemporaneous measures of self-image), and ratings by self and by others be regarded as different methods.

Unfortunately, the data do not permit any simple generalizations about method or trait variance. They do appear to suffice for a satisfactory mutual validation of the revised Tennessee and the teacher-counselor ratings, despite the 12-year interval between these measurements. Though none of the longitudinal correlations "accounts for" more than a quarter of the variance in adult self-esteem, and that fraction is of limited value in individual prediction, still it indicates a substantial degree of stability. As a point of reference for evaluation of this longitudinal correlation, we may compare the results of Bachman and O'Malley (1977), whose study may be the nearest antecedent to the present investigation of the long-term stability of self-esteem. These authors used an adaptation of the Rosenberg (1965) Self-Esteem Scale, with a

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reliability of .75, on a sample of 1608 hearing young men, who had been in the tenth grade on the first round. In their eight-year follow-up, they found a longitudinal correlation of .46, which is quite comparable to the present stability coefficients.

Unfortunately, the most striking feature of Table 2 is simply the uniqueness of the Meadow Pictorial Scale of Self-Image (MPSSI). Whereas the other measures of the study exhibit correlations among themselves, both longitudinally and synchronically, in the neighborhood of .5, the MPSSI is uniformly correlated with none of them, nor did it correlate with any of the other variables in the study--psychosocial, communicative, intellectual, or vocational. A scattergram of the Meadow scores against the teacher-counselor ratings shows no discernible pattern, either for children of deaf or of hearing parents. With respect to validating evidence on this instrument, the conclusion would seem inescapable: that the MPSSI is not measuring self-image, and in fact does not appear to be measuring anything at all. In view of its face validity, however, the available plausibility arguments to account for the negative results, and its attractive ease of administration, it seemed worthwhile to try the scale again on a new sample.

TABLE 2

Correlations Between Measures of Self-Image
(N = 62)

		Self-Rating		Rating by Others	
		MPSSI	TSCS-R	Teacher-Counselor	Interviewer
		(Round 1)	(Round 2)	(Round 1)	(Round 2)
Self-Rating	MPSSI (Round 1)	( )			
	TSCS-R (Round 2)	.18/.09	.71		
Rating by Others	Teacher-Counselor (Round 1)	.01	.43/.39	( )	
	Interviewer (Round 2)	.03	.53/.26	.52	( )

NOTE. Empty parentheses mark unavailable reliability figures. The two figures in each entry for the TSCS-R represent the first and second administrations. Underlining denotes longitudinal correlations.

STUDY II

This study was the fifth round of a longitudinal study of prelingually deaf children begun in 1969 by Hilde Schlesinger and Kathryn Meadow, and first reported in Sound and Sign (Schlesinger & Meadow, 1972). A major purpose of the study was to assess the long-term consequences of differences among deaf children in early communicative competence.

Participants

Forty preschoolers, 2 1/2 to 4 years old, were recruited from preschool programs for the deaf in the San Francisco Bay Area. All had an average loss of at least 80 dB in the speech range, and all had been diagnosed as deaf before the age of 12 months, except for one who became deaf at 16 months. To minimize variance extraneous to the purpose of the study, children were included only if they were white, from roughly middle-class, intact families, where both parents were hearing and spoke English; they also had to have no major diagnosed disability other than deafness, and had to be judged not to be retarded or unusually slow by their preschool teachers; finally, they must not have been a twin.

At the time of the most recent round, the fifth, the youngsters were 14 to 17 years old. The spread in their ages was increased by the necessity of spreading their testing over a period of a year and a half.

Measures

The two-day battery of measures assessed cognitive, communicative, and socioemotional functioning. All testing was done with an interpreter highly skilled in all modes of communication with the deaf, who was also a sensitive counselor experienced in working with deaf adolescents. Under socioemotional functioning were included two measures of self-image: the Meadow Pictorial Scale used in Study I, and the more recent Meadow-Kendall Social-Emotional Assessment Inventory for Deaf Students (Meadow, 1983). The MPSSI was administered individually; and, in another departure from the previous study, its component scores were analyzed in addition to the total--both adjectives and perspectives.

The Meadow-Kendall was given to parents as well as teachers. It is true that some items on the Meadow-Kendall are peculiar to the school setting, but the opportunity to compare the perspectives of parents and teachers still seemed worth taking. It should also be noted with respect to the teachers' ratings that they are evaluating in very different contexts. Those in residential schools have very extensive experience with deaf students; some of the teachers in our group, especially those in private schools, have never had another deaf pupil. The same range was also represented, of course, in the standardization sample for the Meadow-Kendall.

Results

Let us proceed by looking first at some relationships internal to the MPSSI and the Meadow-Kendall, then at relationships between them, by way of

discovering their degree of mutual validation. After that, we can look at the relationship of each of these with some other variables in the study, and, finally, pull all of this together to try to explain the pattern of findings.

Because it became apparent during data analysis that there were differences in results on self-image between students attending residential schools and those in other programs, Tables 3 and 4 present triple entries. The first is for students attending residential schools for the deaf ($\underline{N}$ = 14), the second for students in regular public or private schools ($\underline{N}$ = 25), and the third for the whole sample. It ought to be kept in mind in considering the data that the residential/day school distinction, however clear-cut in appearance, is actually a little messy. Students were classified on the basis of their enrollment at the time of their participation in the study; but some of them had just recently switched, and were thus somewhat atypical of their group.

Correlations Internal to the MPSSI. Here one of the more interesting findings is that for day students the relationship between the perspectives of self and mother is much stronger than it is for residential students. (It is, of course, the child's perception of the mother's perspective; but, with this important distinction in mind, this scale will be referred to as the mother's perspective, for convenience.) The obvious possible explanation is just that the students in mainstream programs remain much more closely tied to their mothers, the connection being not just one of physical proximity but of communication. For several of the students in public schools, their mothers are the only ones with whom they can easily carry on a conversation. A similar pattern, interestingly, holds also for the perspective of the teacher: students in mainstream schools appear to be more shaped by their teachers' view of them than do residential students.

A final observation is the uniqueness, for residential students, of the perspective of their peers. Whereas for students in day programs the similarity among perspectives is quite strong, for residential students the scales for peers are unrelated to those for adults. The explanation is not completely clear, though it may reflect a greater importance for peer relationships at the residential schools. In interpreting all of these findings, the possibility should probably be kept in mind that the generally lower correlations among residential students may simply reflect lower reliability due to poorer comprehension.

Correlations Internal to the Meadow-Kendall. The principal findings here concern the relation between parent and teacher ratings. For nonresidential students, the largest intercorrelation is .16, whereas for residential students intercorrelations on all three subscales are greater than .4. Residential school teachers agree with parents more than day school teachers do, perhaps just because residential school teachers know their students better.

Relationship between MPSSI and Meadow-Kendall. Table 3 shows the correlations between the various subscales of each test. In general, they are low, implying that at least one of the instruments fails to be validated. These

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results are consistent with those reported by Meadow (1983), who found corre-
lations of .20 and .28 between the MPSSI and the Self-Image subscale of the
Meadow-Kendall, for academic advisors and dorm counselors, respectively. It
may be noted for later reference that the MPSSI appears to be more closely
related to Meadow-Kendall ratings by parents than to those by teachers. A
possible explanation is the simple fact that children tend to be less
influenced in their self-image by teachers than by parents, who got a head
start.

Relationships between the MPSSI and other variables. Common sense would
predict a positive relationship between self-esteem and academic success,
based on reciprocal causation: academic success would be one source of self-
esteem, and, conversely, the motivational consequences of high self-esteem
should conduce to academic success. In the present group, however, MPSSI
scores relate weakly, if at all, to other measures in the study--to measures
of cognitive, communicative, or socioemotional functioning. It is easier to
take note of the exceptions in this correlational desert. First, among resi-
dential students only, there is a positive, if modest, relationship between
self-image and academic variables such as reading ability. For day students,
in contrast, that relationship is nonexistent or even negative: academically
successful mainstream students often have lower self-esteem than their less
successful peers.

Internally to the MPSSI, it is interesting to note that the adjective
"Smart" is correlated .65 with the perspective of the teacher for day stu-
dents, but not all ($r = -.04$) for residential students. More provocatively,
"Smart" and "Lazy" are correlated -.31 for day students, but +.55 for residen-
tial students. Clearly the two groups are making opposite attributions about
intellectual ability: day students see it as related to work; residential
students evidently see intelligence as innate, so the smart students have to
work less. The evidence of this study, of course, would suggest that the
latter are correct, for their self-ratings of intellectual ability correlate
much more highly with objective measures of their ability than do the academic
self-ratings of the day students.

A further interesting finding with the MPSSI is negative correlations be-
tween cognitive and communicative/audiological variables, on the one hand, and
the perspective of the mother. There appear to be two groups who experience
their mothers as particularly critical: those who are academically
successful--especially those with fluent English language skills--and those
who have better hearing, especially better aided hearing. These are largely
the same group, of course. The inverse relationship with indices of com-
municative and speech competence also gets stronger over time, at least for
mainstream students--almost as if, the further behind the child falls in com-
municative competence, the more accepting the mother becomes. (Speech skills,
incidentally, appear to be more important to self-esteem, at least in their
mother's eyes, for girls than for boys.) There is thus some reason to suspect
here the operation of a double standard, for oral and for manual deaf
children. Better hearing and speech skills induce children and their parents
alike to hold them to the same standards as hearing children--for speech as
well as for reading and other academic performance. These academic standards,

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TABLE 3

Intercorrelations of Subscales of the MPSSI and Meadow-Kendall

	Meadow-Kendall					
MPSSI	SA/T	SI/T	EA/T	SA/P	SI/P	EA/P
Self	-.27	.36	-.07	-.09	.58	-.03
	-.11	.09	.08	.04	.12	.53
	-.07	.25	.03	.04	.36	.26
Mother	-.24	-.00	.19	.18	.35	.36
	-.32	-.27	-.15	-.13	-.01	.39
	-.28	-.18	-.06	-.00	.12	.37
Father	-.23	.28	-.04	.01	.55	.30
	-.10	-.07	-.03	-.06	.05	.26
	-.14	-.01	-.03	-.06	.19	.29
Teacher	-.19	.09	.16	.04	.19	.19
	-.02	.14	.08	-.03	-.22	.34
	.06	.25	.12	.11	.06	.13
Same Sex	.04	.10	-.01	-.34	-.01	.32
	-.08	.06	-.08	.12	.12	.18
	.03	.14	-.04	-.08	.08	.17
Opposite Sex	-.48	.42	-.27	-.50	.14	-.18
	-.23	-.14	-.14	-.16	-.30	.28
	-.20	.14	-.17	-.28	-.05	.06
Hearing People	.02	.38	.11	-.22	.11	.42
	.04	.23	.14	.17	-.10	.50
	.04	.25	.13	.00	-.01	.43
Total	-.15	.42	.05	-.02	.49	.20
	-.18	.00	-.05	.08	-.16	.32
	-.12	.13	-.01	.07	.10	.23

NOTE. In this and the following table, the triple entries for each corre-
lat'n are for residential students, day students, and the combined
sample, respectively.

at least, are not, it must be emphasized, inappropriate for deaf students--
given a history of suitable environments with respect to communication; but
such environments continue to be the exception rather than the rule.
Consequently, standards derived from hearing children pose a stiff challenge
for even the most fortunate among the profoundly deaf, who chronically find
themselves falling short in one way or another. If parents at some point
abandon the hope of successful speech and hearing for their deaf children,
then other deaf students implicitly become the reference group; and there are

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definite psychological advantages when both child and parent become more relaxed and accepting of limitations.

It should be borne in mind here that self-este is not just an issue of standards for self-evaluation, but also a matter of identification; and deaf children attending public or private schools face unique and serious problems just from this standpoint. It has often been observed (e.g., Derbyshire, 1968), with respect to acculturation of ethnic minorities, that those who suffer most in self-esteem are those who are caught most squarely in the middle, and can identify strongly with neither the pare t nor the host culture. Children of immigrant parents, for example, tend to have more self-esteem problems than either their parents or their children (e.g., Knight, Kagan, Nelson, & Gumbiner, 1978). Seward (1958) maintains that, in circumstances of forced acculturation, the more firmly individuals are identified with their subgroup, the better the integration they are likely to make with the mainstream culture. The implication that early identification with the deaf community I beneficial to the self-esteem of deaf youngsters might be taken simply as supporting common sense.

One final set of results, just recently obtained, fits with the foregoing observations and also extends them. At the First National Conference on the Habilitation and Rehabilitatioin of Deaf Adolescents, Acree (Schlesinger & Acree, 1984) reported the very controversial impression that it was difficult for profoundly deaf adolescents to succeed simultaneously in the academic and social realms. This impression had mainly to do with the simple fact that academic standards are generally higher at public and private schools than at the residential schools, yet severely hearing-impaired students in those settings tend inevitably to be socially isolated. Some further, poignant support is now available from an indirect but interesting source. Early interactions of these youngsters with their mothers, roughly at ages 3 and 6, have been scored for various dialogue characteristics. One of the best predictors of adolescent academic success has proved to be the young child's initiative in dialogue--asking questions, pointing things out, giving directions, and so on. Similarly, as was reported two years ago (Schlesinger & Acree, 1984), adolescent academic success is predicted by the mother's responsiveness to the child, following his or her lead.

Unfortunately, the best predictor of self-esteem--as measured by the MPSSI--is the child's responsiveness to the mother. As the illustrative correlations in Table 4 show, self-esteem on the MPSSI tends to relate negatively to the child's spontaneity. These correlations are from Round 2 of the study, when the children were approximately six years old.

The picture becomes a little clearer when we add the Meadow-Kendall. Here a sharp distinction emerges between ratings by parents and by teachers. Parental ratings tend to parallel the MPSSI; on the Emotional Adjustment subscale, particularly, they are related negatively to the child's spontaneity and positively to the child's responsiveness to the mother. Teacher ratings, on the other hand, parallel the findings with academic measures: childhood initiative correlates positively with teacher ratings of the child's self-image, while responsiveness correlates negatively. Indeed, some of the items on the Meadow-Kendall call for a direct appraisal of initiative, curiosity,

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TABLE 4

Correlation of Selected Dialogue Characteristics with the MPCSI
(Round 2)

Mother	Self	Mother	Teacher	Same Sex	Opposite Sex	Total
% Responsive	.02	−.05	.39	.32	.08	.20
Statements	.12	−.02	.26	−.07	.10	.09
	.11	−.03	.37	.10	.12	.15
% Spontaneous	−.02	.24	−.39	−.32	−.08	−.20
Statements	.13	.24	−.09	.18	.05	.09
	.01	.16	−.29	−.04	−.05	−.05
% Control	−.45	−.07	−.17	−.19	−.52	−.34
Statements	.41	.30	.19	.31	.35	.36
	−.05	.14	−.10	.05	−.09	.03
# Statements	−.06	−.02	.00	.21	.24	.01
Per Minute	−.68	−.50	−.60	−.48	−.40	−.59
	−.46	−.37	−.34	−.27	−.18	−.42
Child						
% Responsive	.09	.42	.^)	.52	.06	.51
Statements	.23	.27	.17	.23	.45	.31
	.17	.32	.31	.32	.30	.37
% Spontaneous	.02	.22	−.31	−.52	−.16	−.19
Statements	−.23	−.27	−.16	−.23	−.45	−.31
	−.12	−.25	−.18	−.32	−.33	−.26
% Control	−.45	−.29	−.16	−.27	−.53	−.22
Statements	−.12	.12	.01	−.02	−.01	.07
	−.17	.04	.01	−.05	−.12	.03

and related characteristics. These findings echo the results reported earlier, that the MPSSI--the child's own rating of self-image--correlates more highly with the parent's perception (as perceived by the child) than with the teacher's perception. They also help to support and explain the finding in Study I, that teacher-counselor ratings were especially good predictors of later functioning in a variety of areas. Teachers, evidently, are closer to rating the child's actual capacities. They are really rating their esteem for the child, and not the child's own self-image. The children, on the other hand, are nearer to reflecting their mothers' view of them than their own actual assets. Both the child's actual capacities and self-image are relevant to development and achievement; but, on the attributes measured, both of these studies point, interestingly, to a more decisive influence by the former.

It also seems clear that what parent and adolescent alike mean by a good child amounts largely to obedience. To be well-adjusted, it seems, is to be well-adjusted to one's mother. But it is independence and initiative, rather than compliance and responsiveness, which tend to lead to achievement--and, arguably, to a healthy self-esteem. These considerations would suggest that, to a certain extent, children face an implicit choice between success and self-esteem--at least until they are old enough to refashion a more appropriate standard of self-esteem. There also appears to be nothing in this line of reasoning to indicate that it is peculiar to deaf children.

DISCUSSION

The central finding to emerge from these two studies is that the Meadow Pictorial Scale of Self-Image fails to correlate with other measures of self-image, and does not correlate appreciably with most other measures in these studies. It is now time to acknowledge a fundamental dilemma which has thus far been evaded by alternately embracing both horns. The usual response to this finding, as suggested above, is to conclude that the MPSSI is not, after all, a measure of self-image. It is important to note that reaching this conclusion requires the assumption that the relationship of self-image to other variables, such as academic success, is essentially simple (linear).

A logically coherent, and interesting, alternative, however, is to entertain the idea that the MPSSI really is measuring self-image, but that the relationships of self-image to other variables are complex--for example, nonlinear. This idea is worth pursuing, just because some of the results reported above specifically lend support to this possibility. Let us review the evidence in summary.

Nonlinearity. The relationship of self-image to a number of other variables, notably cognitive and communicative, may be approximately linear, but only up to a point. At a point where deaf adolescents are functioning well enough to seduce their parents--or themselves--into applying the same standards as they would for hearing children, their self-esteem reverses.

Ratings by self vs. other. Ratings by teachers correlate much better with other measures than do self-ratings. Comparison with parental ratings led to the suggestion, however, that teacher ratings may not really be measuring the child's self-concept. In fact, to judge another person's self-image is a task of considerable stubtlety and difficulty, even for sensitive and clinically minded adults. The Meadow-Kendall, indeed, does not ask for such judgment; it calls instead specifically for the teacher's appraisal of the child on certain behaviors, which are essentially assumed to reflect the child's self-appraisal.

Cognitive competence presupposed by the MPSSI. If assessing the perspective of another is a delicate task for adults, there would certainly be reason to question the ability of many deaf children and adolescents meaningfully to complete the MPSSI, which explicitly requires them to take up a multiplicity of perspectives on themselves. Research evidence on hearing children is somewhat equivocal with respect to their ability to take the role of the other. The nature of the task cannot strictly be compared across different

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studies and the MPSSI; but in one rather careful developmental investigation of 6-, 9-, and 12-year-olds, Calveric (1974) found that perspective-taking ability was not securely consolidated even in her oldest group. On the MPSSI, our principal evidence for the adolescents' competence in completing the task lay in the differentation among perspectives as reflected in the variability of their scores.

Relationship to parental perception. One of the few variables to which the MPSSI does relate, in Study II, is the parents' perception, on the Meadow-Kendall; and the parental Meadow-Kendall, reciprocally, does not relate to much of anything except the Meadow Pictorial Scale. Mothers, at least in our sample, tend to value children who are obedient and responsive to them; and the children tend to assimilate their mother's view of them. These characteristics are not, however, predictive of the achievements generally associated with self-esteem.

In sum, it is not unreasonable to conclude, in light of the evidence of these two studies, that the Meadow Pictorial Scale, at least when carefully administered to adolescents on an individual basis, does measure self-image, but that the concept of self-image, and its relation to other attributes, is more complex than usually supposed. The more "standard" conclusion, that the Meadow Pictorial Scale is an invalid instrument for self-image, is also viable, but is supported mainly by the assumption that the relationship of self-image to academic and communicative variables should be simple. A deci- sive demonstration would be hard to produce; but this pair of studies may still have served a useful purpose in pointing, first, to an alternative understanding of self-esteem and a supporting interpretation of the evidence, and, second, to the need for a more sophisticated approach to validation of measures of self-image, for hearing as well as deaf adolescents.

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CONSCIOUSNESS-RAISING WITH
DEAF FEMALE ADOLESCENTS

CHRISTINE RAE BOUNDS

The origin of Consciousness-Raising Groups are
discussed with special applications for deaf adolescents.
Specific techniques for the group leader of a
consciousness-raising group for deaf women are delineated.
Interest surveys of 49 deaf, female adolescents reveal that
life styles, childbirth, marriage, and gynecological health
are the most popular topics. Homosexuality, menstruation,
non-traditional careers, and masturbation are the least
popular topics. The implications of these surveys are
discussed. Deaf adolescent women are confronted with many
issues. Consciousness-raising groups are an effective tool
for dealing with deaf, adolescent female's concerns.

In 1966-1967, the pioneers of the feminist movement initiated
consciousness-raising groups as a tool of political change. The organization
which spearheaded the use of consciousness-raising groups (C-R groups) was the
National Organization of Women (N.O.W.). As a routine procedure when a woman
signed up with N.O.W., she was almost immediately asked if she would like to
become a member of a C-R group.

The format of the C-R group involves women raising areas of concern which
are generated by the members' common gender. Researchers, such as Barbara
Kirsch, feel that C-R groups are therapeutic and can result in positive
changes in mental health. However, there is one major difference between a
C-R group and a traditional psychotherapy group.

The individual is the unit of change in psychotherapy. In contrast,
the goal of the consciousness-raising groups is to change the social
structure and culture through the individual. A psychotherapeutic
point of view explains problems in terms of personal inner dynamics,

while a feminist perspective looks to the sociocultural context as explanation for what appears to be Individual conflict, tension, or discomfort.

(Kirsch, 1974, p.326)

C-R groups may meet from a duration of a few months to two years with a membership of 5 to 12 persons. As a general rule, C-R groups include women of all ages, races, and socioeconomic status.

Generally, women meet with the purpose of discussing common concerns arising out of the female sex role. C-R groups have some common phases:

1. Opening-up: The women may have been coping with feelings of stress alone. In a C-R group, they open up to others for perhaps the first time.

2. Sharing: The group begins to perceive that members share some of the same depressions and pains caused by their suppress on in a male-oriented society.

3. Analyzing: The C-R group looks at the position of women as a whole.

4. Abstracting: The final phase is political. At this stage, the members decide how they can make changes for improvement of the inferior role of women in society (Kirsch, p. 343).

Kirsch (1974) has incorporated unpublished data regarding the results of C-R groups. To summarize the results, women participants in C-R groups began to identify and define themselves without reference to their roles as someone's mother, wife, lover, or daughter. Kirsch (1974) has found in her review of the literature that members of C-R groups develop improved self-esteem and autonomy. Women also reported that they developed a greater appreciation of all the stereotypes surrounding motherhood and they began to view their mothers with a different perspective. Women within C-R groups developed strong feelings of closeness and support. C-R groups permitted members to have a catharsis of anger and frustration at the cohumanization of women in society. Another major outcome of C-R groups was a more relaxed attitude towards their bodies and increased feelings of competence as sexual partners (Kirsch, 1974). Women who were in C-R groups began to establish more egalitarian relationships with men. Also, women began to establish more respect for effectiveness of other women (Kirsch, 1974). Annette Brodsky (1976) feels that C-R groups help show women that sex discrimination really does exist and the group develops more assertive behavior to combat that discrimination.

In 1966-67, feminists had as their goal the establishment of equal relationships between other women and men; the C-R groups were originally organized without a leader. The lack of a leader resulted in several rules: each member had her turn to speak; each member spoke without criticism or interruption by the other participants; there was no dominant speaker, each

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woman was the best authority on her own life; members were to respect and tolerate values of others; and members were to be supportive but not advisors to each other (Williams, 1977).

Feminists determined that the lack of a leader resulted in power plays within the groups and a general sense of frustration due to the lack of structure. So in 1975 a C-R manual was developed by N.O.W. with specific techniques to be used by a trained leader. The leader of the group was to use these techniques as a way of meeting these 4 goals: (1) building self-esteem; (2) building feelings of sisterhood and unity among the members; (3) recognizing the anger that group members experienced about their oppression; and (4) developing plans for political change.

Topics arising out of C-R groups were: women's bodies, orgasm, lovemaking practices, lesbianism, extramartial sex, group sex, masturbation, menstrual cycles, male-female relationships, discrimination, managing misery, parents' attitudes toward their daughter, housework, and child care.

IMPLICATIONS FOR THE USE OF C-R GROUPS FOR DEAF WOMEN

The writer has been an active participant of two C-R groups, consisting of hearing women, even though the writer has a moderate hearing loss. When the writer accepted a position as a school counselor at a co-educational high school for deaf students, she decided to modify the C-R group with a segment of the female population. The writer had found the C-R groups very meaningful to her and felt that female students could benefit by a C-R group.

Women share with other minority groups these characteristics: low self-concept, insecurity, submissiveness, and low goals. Goldberg did a study with female college students reading the same 6 articles, but identifying these articles with female name and male names. The female students consistently ranked the articles with male names as a higher quality than those with female names.

If women in general were experiencing so many difficulties as a minority status group, how would deaf women, a minority within a minority, build positive self-concepts, pride in their womanhood, and respect for each other as women? The writer felt that deaf adolescent women needed to analyze these issues of their emerging self concept, their sexuality, their relationship with peers, their vocational decisions, and deafness itself.

The C-R group for deaf female adolescents should have a qualified leader, namely a trained professional in the field of mental health. Deaf female teenagers exploring their psyches need a qualified leader. Although C-R groups with hearing women had excellent results, they sometimes floundered without a leader. A group of teenagers especially need a leader to guide students throught the group process.

C-R groups have been occurring at MSSD for a total of nine semesters. The group leader has varied greatly in her approach to differences in how groups were scheduled at MSSD. At the time that the first group was scheduled, students wanting to receive group counseling designated that they wished to be in

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a group. All of these students happened to be female. As a result, the first C-R group was scheduled. The first C-R group was motivated to be in a group and a true therapy group was created. The members of the group brought up concerns which were relevant to its participants. The group leader occasionally suggested topics, but the students often found that other concerns had more meaning for them. The group leader often discovered that the students had many medical questions, and a school nurse was invited several times to the group. The students asked questions about sexuality which the leader sometimes needed to investigate and brought the answer to the group at the next session. One of the frustrations that a teacher of deaf students often encounters is that one cannot instruct the students to hunt down the answers in a reference book, because 60% of deaf students 16 or older read at or below the 5.3 grade level (Mindel & Vernon, 1971). There are very few reference books on sexuality which are written on a fifth grade level or lower. Most of the students on their own initiative bought the book, Our Bodies Our Selves, and few could comprehend it correctly. However, all of the students really enjoyed studying the photographs in this excellent book as a source of information. This particular group due to flexibility in the school scheduling met twice a week during the first semester and once a week during the second semester. One measure of this particular group's success was at a class, which Della and Max Fitz-Gerald hosted, at which time nearly all the students voluntarily observed how meaningful the group was to them.

The second group was designed in a different manner. The leader contacted various students whom she thought would enjoy discussing female sexuality. All the participants knew each other and several were good friends with each other. Therefore, group intimacy was quickly attained.

This group was scheduled for once a week for one semester. In the meantime, the leader had completed three courses in human sexuality through the American Association of Sex Educators, Counselors, and Therapists. At this point she found she could more readily provide answers to students' questions. Due to the reduced number of sessions, a more instructional approach was taken. The topics of female anatomy, menstruation, menopause, self-defense, pregnancy, childbirth, parenting, contraception, abortion and non-traditional careers for women were covered in approximately fourteen sessions. The group was given encouragement to raise concerns. One guest speaker who had spoken about sexual assault at both the college level and the high school level felt that this group raised far more astute questions due to their possessing a higher level of sex knowledge and comfort than the college students.

Later, the group was transformed into a class-like atmosphere. This evolution occurred, not as a result of the wishes of the group leader but rather as a change in method of scheduling group counseling. For an activity to be scheduled by the school, the activity was termed a class and students were given a pass-fail grade. Also, students were scheduled together who had a variety of communication styles, sexual experience, language facility, and sex knowledge. Group intimacy was a little harder to achieve than when a group leader interviewed the students and grouped students together based on some degree of homogeneity. Another factor, impeding group rapport, was the fact that classes determined at Individualized Educationa' Program (IEP) meetings for deaf students may result in a student taking a class due to an academic advisor's or parent's insistence.

However, despite these flaws, the classes (groups) usually achieved a strong sense of cohesion and allowed the students to discuss a variety of sensitive areas.

Currently, C-R groups are held after school on an entirely voluntary basis. Sometimes scheduling around various extracurricular activities can be frustrating. However, two students have chosen to remain in the C-R group for the duration of the entire school year. Also, the informality of the after-school approach does result in the students' owning the group more readily and a rapidly escalating exploration of many issues.. The C-R group currently in progress (Spring, 1986) is really more characteristic of a "therapy" group than a "counseling" group.

In the future, the leader hopes that group counseling can be scheduled on a totally voluntary basis and that the composition of the group's members can be determined by the group leader based on some minimal degree of homogeneity among the members. However, to ensure more consistent attendance, the writer would like to see groups scheduled during school time.

Despite the students' original motivation for signing up for the C-R group, most students have a large number of questions due to a belief in a number of myths. These myths include: "hickies cause cancer;" pregnancy is caused by some mysterious event other than intercourse; all contraception is equivalent to the birth control pill; urination is experienced at the vagina; and the natural way to have sex is without contraception.

On the first or second session of almost all the C-R groups, the leader distributed an interest survey. This survey has been administered to a total of 49 students, female and deaf. The results are presented in Figure 1.

The women students surveyed are most interested in the following topics (highest means to lowest): lifestyles, childbirth and pregnancy, marriage, gynecological health, abortion, values, female anatomy, premartial intercourse, birth control, male anatomy, venereal disease, divorce, relationships, menopause, rape, homosexuality, menstruation, work in traditonal man's job, and masturbation.

As for the highest interest, "Life Styles", deaf students probably realize that knowledge about lifestyles is often presented in conversation and media. The students chose "Life Styles" because of their wish to be kept abreast of modern trends in society about which they are ill-informed. As for the second highest interest, childbirth and pregnancy, students are acutely aware that the etiology of their deafness is often linked with events occurring during prenatal development or during birth. Therfore, the interest of deaf students in childbirth is an attempt to understand their deafness and how to preserve the health of their future children. Most students are eager to learn about proper prenatal care. Students that use any form of chemical substance realize the danger of this behavior if this behavior is continued throughout the pregnancy. The group leader uses videotapes showing the effects of drug use and alcohol comsumption on the part of pregnant mother's offspring. These videotapes invariably elicit a very strong response, leaving the impression that teenage women give second thoughts to chemical substance abuse during discussion of prenatal life.

FIGURE 1

Student Questionnaire

Fill in: Check topics with a (1) If very interested, check (2) If you have a lot of interest through to (5) if you think it is boring. Age:_____

MEANS OF
49 STUDENTS

2.4	Male Anatomy (parts of body)
2.2	Female Anatomy (parts of body)
2.2	Premarital Intercourse (sex before marriage)
3.6	Masturbation (play with yourself)
3.1	Menstruation (monthly period)
2.6	Menopause (woman begins to stop having periods)
2.1	Marriage
2.5	Divorce
2.1	Abortion (stopping pregnancy by operation)
2.3	Birth Control (IUD, condom, birth control pills)
2.2	Values (your opinion about sexuality)
1.8	Life Styles (living together, open marriage)
1.9	Childbirth and Pregnancy
2.4	VD (veneral disease through sexual contact)
2.8	Homosexuality (sexual interest in the same sex)
2.5	Relationships (getting along with others)
2.6	Rape
2.1	Gyn Health
3.2	Work in traditional man's job

Another outcome of discussing pregnancy and childbirth is that students go home and ask more questions about the etiology of their deafness. Students often are confused about specific circumstances surrounding their deafness, and channels may be opened up between parent and child regarding this topic. The leader encourages conversation with parents concerning circumstances surrounding their prenatal and early childhood development.

A low interest of the students is masturbation. No female student has ever brought this topic up in the group. The leader generally assures the students that no harm can ensue from the practice of masturbation.

Another extremely low interest of the female students is working on non-traditional careers. One observation that the leader has made is the very traditional outlook that female students have regarding appropriate sex roles. Research conducted by Cook and Rossett (1975) indicates that deaf women at Gallaudet College and NTID were significantly more traditional (.005 level) in their perceptions of sex role attitudes than hearing college students. This research confirms the need for groups and classes where female sex roles are examined.

In listing some of the characteristics of females, the group members have stated that women do the clean'ng; they are the softer and smoother sex; women talk more than men; women get frightened more easily than men; women have a harder life than men; women worry about pregnancy and periods. Because of this obvious traditional sex role orientation, the leader includes a unit on non-traditional careers for women. One of her guest speakers has been a female electrician's helper. One session of the class was fortunate in hearing both the electrician's helper and her husband's feeling of jealousiv of his wife's male co-workers. That particular class opened a lot of students' eyes to the pride, higher salary benefits, and difficulties in a non-traditional career.

Most students are ary open with their discomfort at knowing if and when to draw the line at sexual activity with boys they know. When the leader asks the students how they feel about premarital sex activity, the students are often unable to give an opinion. The students have not arrived at a decision about what levels of sexual activity feels "right." Some girls are letting boys make the decision for them regarding level of sexual participation. Role playing can be a useful tool in discussing premarital sexual activity.

How the students relate to their parents regarding sexual topics vary: some students have an excellent rapport with their mothers, but usually not with fathers. In this respect deaf female students seem similar to hearing female students.

Roberts (1978) Executive Director of the Project on Human Sexual Development, did a study involving over 400 parents. This research found: Perhaps because many fathers do not spend as much time with their children, especially their young children, or simply because children find their mothers more approachable, children do not bring their questions to Dad. Both sons and daughters take almost all of their questions about sexuality to their mothers.

Other students find they have no communication with either parent or they only receive ominous warnings about sex. Athanasious (1973) discovered that only 12.1% of the population received sex education from their parents. Deaf persons, as well as hearing persons, may not find sex education in the home.

CONCLUSION

It is this counselor's opinion that deaf and hearing women suffer from the same problem, lack of power in the American society. Deaf women, however, face a double impediment: they are rejected from the mainstream of society on the basis of their gender and disability. In addition, hearing women have Kate Millets, Gloria Steinems, Germaine Greers, and Betty Friedans for inspiration. Deaf women can not hear these feminists on television, radio or public appearances at any time as hearing women can. Deaf women need feminist leaders, too.

Both deaf and hearing women are working in underpaid traditional women's jobs such as teaching and clerical positions; doing most of the household duties; deferring to the masculine decisions of the household; receiving sexist treatment by doctors and police; supporting single parent homes with less money than the paternal single parent homes; being discriminated against by antiquated laws; not being allowed to make their own decisions about their bodies; being frustrated by a lack of good and economical child care; being told they should be reaching multiple orgasms by their partners; being represented as mindless or hysterical individuals by advertising media; and dealing with male administrators and male political leaders.

Obviously, consciousness-raising groups can offer much to both deaf and hearing women. Zweig (1971) tells us this about what women find in consciousness-raising groups:

> She will receive sisterly warmth, affection, friendship, and sympathy from other members of the group. She will receive respect and appreciation for her abilities, and will be treated with honor and dignity by her fellow group members (Zweig, 1971, p. 162).

The author hopes that this paper will encourage the development of C-R groups among deaf, and other disabled, groups across the country. The author feels that if C-R groups were developed with a combination of deaf and hearing women that deafness itself would become the focus. The proper focus of a C-R group is those issues confronting only women.

The goal of C-R groups for young women in all classes, ages, ethnic groups, disabilities and other states of being is an improved self-esteem. When women improve their self-esteem, they improve in other ways. Maslow found:

> . . . that women who were high in self-esteem were also tolerant of others, assertive, willing to take initiative, decisive, self-reliant, independent, and ambitious. They permitted themselves a wider range of sexual experience, had no fear of the body or its organs, and eschewed altogether the double standard of sexual behavior (Williams, 1977, p. 343).

In 1851, a famous feminist, who suffered from a double handicap, black and female, had this to say about women's goals:

If Eve, the first woman God ever made, was strong enough to turn the world upside down all alone, these women together ought to be able to turn it back and get it right side up again (Alexander, 1975, p. 1).

The sooner deaf and hearing women try to get the world right side up again, the sooner all women will rejoice in an enlarged achievement and a richer sexuality.

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ADAPTING AND EVALUATING SOCIAL SKILLS CURRICULA FOR USE WITH DEAF ADOLESCENTS

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GREG LONG
NANCY LONG

Social Skills Training (SST) represents a label for a number of psychosocial treatment strategies frequently recommended for use with a wide variety of disabled persons. Despite the frequent recognition of social skills deficits exhibited by hearing-impaired adolescents, there remains a shortage of SST materials for this population that have been rigorously evaluated. This paper describes efforts to meet this need conducted at the Arkansas Rehabilitation Research and Training Center on Deafness and Hearing Impairment. The development and evaluation of two social skills-oriented curricula, The New Assertive You (N. Long, 1986) and Goal Setting Skills Training (G. Long, 1986) are reviewed. Conclusions regarding future directions and recommendations for the use of these packages with deaf adolescents are drawn and discussed.

Educators and rehabilitation practitioners frequently describe the social skills deficits of the deaf adolescents they serve and identify this area as a significant training need. Despite the rapid development of social skills packages for a wide variety of special populations (see excellent reviews by Bellack & Hersen, 1979; Kelly, 1982; L'Abate & Milan, 1985), there remains a shortage of empirically-validated materials that have been specifically designed in light of the unique needs of deaf persons. Responding to this need, the Arkansas Rehabilitation Research and Training Center on Deafness and Hearing Impairment (RT-31) initiated a program of research to adapt and evaluate social skills training curricula (SST) for use with hearing-impaired people. The two specific skill areas that were addressed in this effort include assertive skills and goal setting skills. The purpose of this chapter

is to describe the development and research validation of these two training programs.

Organizationally, this chapter includes four major sections. First, a contemporary definition of social skill and a brief review of the social skill deficits reportedly exhibited by many deaf persons will be presented. The second section describes The New Assertive You (N. Long, 1986), an assertiveness training package focused on rights, responsibilities, and consequences. The third section describes Goal Setting Skills Training (G. Long, 1986), a program designed to enhance the ability of deaf adolescents to set goals and to carry them out. Finally, questions directing future research with these packages and recommendations for their use are drawn.

SOCIAL SKILLS: DEFINITIONS AND RELEVANCE FOR DEAF ADOLESCENTS

A large body of literature has accumulated during the last 20 years that has developed social skills assessment and training materials for a number of special populations. Unfortunately, there is a lack of consistency in the definitions of social skill used in these studies, a problem that led Curran (1979) to conclude, "everyone seems to know what good and poor social skills are, but no one can define them adequately" (p. 321). The specific definitions proposed are as varied as the populations studied and the various research laboratories that have conducted these investigations. Despite these inconsistencies, a close scrutiny of this literature identifies a number of components common to most definitions which, if combined, may reflect a consensually agreed upon view of social skill.

Kelly (1982) incorporated these components into a definition that describes social skills as "identifiable, learned behaviors that individuals use in interpersonal situations to obtain or to maintain reinforcement from their environment" (p. 3). This broad definition implies that social skills are goal directed (e.g., obtaining instrumental or relationship-oriented goals), situationally-specific (e.g., occur and are expressed in a specific context), identifiable (e.g., may be observed or reliably measured), and learned (via social learning mechanisms).

Traditionally, much of the SST literature has focused on specific behaviors that are related to an external judgment of social competence. For example, Eisler, Miller, and Hersen (1973) noted that when compared to less skilled persons, the socially competent operationally speak louder, respond more rapidly to others, give longer replies, evidence more affect, are less compliant, request more exchanges and are more open-minded in their expressions. These and other similar behaviors (e.g., eye contact, body posture, voice volume) have become the content of SST programs which typically utilize a number of active-directive teaching methods and behavioral procedures to produce changes in targeted behavior. A large body of literature has shown that these methods are successful, at least in terms of producing acquisition and improvements in client skills. Unfortunately, the literature has been far less conclusive regarding the generalization and use of targeted skill in nontraining settings.

Contemporary theorists have expanded the scope of social skills models to include feedback-loop theories (Trower, Bryant, & Argyle, 1978; Wallace,

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Nelson, Liberman, Aitchison, Luckoff, Elder, & Ferris, 1980; McFall, 1982; Schlundt & McFall, 1985). As an example of these expansions, Wallace et al. (1980) incorporated three component processes into a usable definition of social skill. Exhibiting a socially skilled response begins with "receiving skills," in which the person sizes up the parameters of the interpersonal situation, his/her previous experience with similar situations, and the goals for the interaction. This information is then translated via "processing skills" into a potentially effective response or strategy to use in the situation (i.e., generating, evaluating, and choosing an appropriate response). Finally, the individual delivers this response using good verbal and non-verbal "sending skills." The impact of the response is then monitored and incorporated into the ongoing sequence of behavior if viewed as competent.

Although there have been no studies documenting skill deficits exhibited by deaf persons based on this model, it is likely that deafness as a disability may impact one's receiving, processing, and sending skills (Long, Boone, & Rosten, 1986). In addition to these effects, there is a large body of literature that has described the social skills deficits of deaf persons on a global level, and documented the impact of these deficits across the lifespan. These deficits are likely to be related to deficiencies stemming from lack of exposure to socially skilled models as well as limitations in the value of verbally-based feedback related to the disability of deafness per se. For example, Greenberg, Kusche, and Smith (1982) argue that "deaf children do not acquire a complete understanding of norms, values, and attitudes of the majority (hearing) culture . . . (and) miss the linguistic content of communication (especially in) messages conveyed by the parameters of speech such as innuendo and intonation" (p. 2). Furthermore, in many instances "they are also deprived of social education with regard to deaf subculture" as a function of inadequate exposure and interaction with deaf adults.

Others have described these social skills deficits in more traditional terms. For example, deaf youth have been described as experiencing social, behavioral, and emotional problems at prevalence rates that are 3 to 6 times as common among deaf children than hearing peers (Meadow & Trybus, 1979). Similarly, deaf persons as compared to hearing peers, have been described as easily frustrated and lacking in insight and empathic ability (Rainer, Altshuler & Kallmann, 1969), as emotionally and socially immature (Schlesinger & Meadow, 1972) and as experiencing a high incidence of behavior disorders charactered by impulsivity, shortsightedness and low internalized control (Altshuler, Deming, Vollenweider, Ranier & Fendler, 1976).

These deficits impact upon the deaf adult's life in a number of ways. Describing deaf rehabilitation clients, Bolton (1976) notes many are "deficient in the common knowledge and basic social skills that the average hearing person takes for granted" (p. 9). Similarly, McHugh (1975) notes that many deaf workers are more likely to lose their jobs for personal and social reasons than from poor job performance. In addition, Ford (1985) points out that "lack of social skills interferes with the establishment of healthy long-term work and personal relationships with other deaf adults as well as hearing individuals with whom they can communicate" (p. 87). These descriptions clearly document a need for preventive and remedial programs that target improving the social skills and social competence of deaf persons, a population that is clearly at risk (Emerton, Hurwitz, & Bishop, 1979).

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THE NEW ASSERTIVE YOU

Originally pioneered by Salter (1949), Wolpe (1969) and Lazarus (1971), assertiveness training has become a widely used set of training procedures designed to remediate social skills deficits. Alberti and Emmons (1974) define the goal of assertiveness training in comprehensive terms, identifying the product of training as "behavior which enables a person to act in his or her own best interests, stand up for himself (herself) without undue anxiety, to express his (her) feelings comfortably, or to exercise his (her) own rights without denying the rights of others" (p. 2). Assertiveness training programs focus on many behavioral dimensions including initiation, maintenance and termination of conversations; "standing up" for individual rights; initiation and refusal of requests; giving and receiving compliments; and recognition and expression of justified anger and annoyance in appropriate ways.

The literature on the topic of assertiveness/social skills training procedures points to successful utilization with psychiatric populations (Goldstein, 1973; Hersen, Eisler, Miller, Johnson, & Pinkston, 1973), nonwhite adults (Cheek, 1977; Landau & Paulson, 1977), stutterers (Coleman, Butcher, & Carson, 1980), marital counseling clients (Eisler, Miller, Hersen, & Alford, 1974), job-seekers (Wheeler, 1977), and women experiencing difficulties in interpersonal and job-related situations (Coleman, et al., 1980). In light of these findings, these interventions are frequently recommended in rehabilitation settings. For example, Jung (1978) notes that assertiveness training may be especially useful for disabled persons as they prepare to deal with situations related to employment including job-seeking (e.g., interviewing, assertiveness on the job), and job-keeping (e.g., interacting with co-workers, preventing exploitation, interacting appropriately with employers and supervisors subsequent to obtaining employment).

Despite these recommendations and the potential benefits to be derived from training, the use of assertiveness training as a social skills technique appropriate for use with hearing-impaired persons has not yet been thoroughly or systematically evaluated. In the past decade, only two studies have been reported which evaluate the use of assertiveness training packages with hearing-impaired persons (Sedge, 1982; Turnbow, 1983). Although these studies addressed different age groups with markedly different ages at onset for hearing impairment (adult servicemen vs. 8-11 year old children), both reported successful implementation of assertiveness training programs with hearing-impaired persons. In light of these results, the present study was designed to develop and evaluate the effectiveness of an assertiveness training program in remediating social skills deficiencies of deaf adults currently receiving vocational rehabilitation services. Of particular interest were the effects such training might have on social adjustment, self-image, emotional adjustment, aggressive/passive behaviors, and impulsivity of deaf persons.

The New Assertive You (N. Long, 1986). Review of the literature on available assertiveness training programs resulted in the selection of two packages (Palmer, 1977; Alberti & Emmons, 1974) as a guide for developing the curriculum. Activities included in the training program were designed to help participants: 1) make accurate discriminations between aggressive, passive,

and assertive behaviors; 2) identify, accept, and assert personal rights; 3) recognize and accept the rights of others; and 4) assert appropriate self-control in situations where communication difficulties are experienced. This information is presented to participants in an eight-chapter handbook that includes the following topics: "What is Assertive Behavior?; Strength and Power and Making Choices; Rights and Responsibilities; Asking for What You Want; Saying "No"; How to Deal With Criticism; How to Give and Accept Compliments; Being the New Assertive You."

An accompanying Leader's Manual was developed to provide guidance and assistance to group leaders who use the package. The leader's manual followed the chapter format of the participant's handbook with additional information provided on chapter objectives, description and discussion leads, group exercises and carry-over assignments for participant generalization.

## Research Conducted With The New Assertive You

The curriculum was evaluated using a three group pre/post test experimental research design. Thirty residential clients of the Southwest Center for the Hearing-Impaired participated in the study. All subjects were profoundly deaf and of low to low average intelligence; there were 18 males and 12 females evenly distributed among the experimental groups. The subjects were assigned to an Assertiveness Training group (AT), a Pseudotreatment Control group (PTC), or a No Treatment Control group (NTC). Subjects were assessed on all measures at pretest and again at posttest. During the interim 4 weeks, the AT group received the assertiveness training package two times per week for one and one-half hours; the PTC group met on the same schedule "to discuss job problems;" and the NTC group participated in regular agency activities. The AT and PTC programs were conducted by SCHI staff who were trained for purposes of this study to implement the intervention programs.

To evaluate the program, multidimensional measures of assertiveness, social adjustment, and impulsivity levels were included in the assessment battery. These measures were selected in consideration of the language, comprehension, and reading levels of the participants. The Children's Assertive Behavior Scale (CABS; Michelson & Wood, 1982) was selected as a self-report measure of assertiveness due to its required 4th grade reading level and use of clear and simple examples. The Meadow/Kendall Social-Emotional Assessment Inventory for Deaf Students (MK-SEAI; Meadow, 1980), was chosen as an other-rated measure of client social adjustment. The Matching Familiar Figures Test, Adolescent/Adult Form (MFF; Kagan, 1965) was utilized to assess clients on impulsivity dimensions.

Research Results and Discussion

There were several interesting and valuable results generated by this study. In general, all subjects tended to improve on all of the variables assessed. In particular, subjects from all three groups demonstrated a significant increase in social adjustment at the $p < .01$ level, and a significant decrease on one dimension of the impulsivity measure at the $p < .01$ level, from pre to posttesting. A marginally significant increase for self-image was

found for all subjects as was a marginally significant decrease in total-time-to-correct-answer, a second impulsivity dimension. Perhaps the most interesting, if not unexpected finding, was a significant interaction at the $p < .05$ level on the assertiveness-passivity dimension. The treatment X pre/posttest interaction is depicted graphically below:

MEAN PASSIVITY SCORES
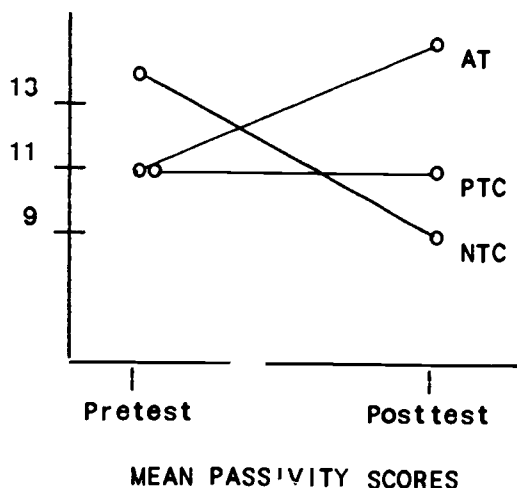
Close inspection of this chart reveals that the members of the AT group were significantly more _passive_ at posttesting than members of either of the other two groups.

There are several plausible explanations for the results obtained by this research project. It is possible that the finding for al! subjects to improve in the same rate in the same direction may be explained in terms of the day-to-day arrangements whereby all study subjects were free to interact and share information on a 24-hour basis. In other words, a spillover effect may have been generated whereby AT group members may have discussed their specialized training activi'.ies with members of the other experimental groups. In addition, it is also possible that the group leaders for this study, who were on staff at the Southwest Center, may have inadvertently incorporated the assertiveness truining techniques into cther aspects of their daily interactions w'th all of their clierts.

The most likely explanation for the unusual results of this study points to weaknesses in the assessment measures utilized. Several results (e.g., for all subjects to show improved performances on some of the variables) may be due to practice effects whereby subjects, because of prior exposure to, and experience with, a measure may show an improved performance. In general however, it seems that the measures utilized, particularly the Children's Assertive Behavior Scale, were not as appropriate for use with the deaf population utilized, as might be hoped. The surprising result fcund w!th regard to the passivity variable serves to highlight the difficulty encountered with the assessment measure utilized. Difficulty was first encountered with the administration of the CABS at pretest as the 3rd to 4th grade reading comprehension level required for utilization of the CABS proved too difficult for self-administration by the subjects/clients. Test administrators modi'led the test by administering it in the sign language communication system appropriate

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for these subjects. Even with this modification, the five respor..e options for each question proved to complicate matters as subjects could not remember all five to make their choice. Answer options were cut to three, thereby possibly sacrificing test sensitivity and validity.

On a morc interpretive level, the finding 1 Jr AT subjects to be significantly more passive at posttest might also be described in terms of weaknesses in the assessment measure utilized for appropriately tapping the dimension of passivity vs. reflection. It is highly probable that subjects of the AT group were responding on a qualitative level; by choosing answers that were scored as highly passive, these subjects may have been indicating that they would take time to consider (or reflect on) their options, as learned in AT, rather than acting out impulsively and aggressively. This interpretation gathers additional support from anecdotal information provided by Center staff who described AT group participants as more aware of the need to take time to reflect on consequences before choosing their response. However, the limitations placed on interpretation of responses called for these results to be labelled as "passive".

In general, the results of this study provide a moderate recommendation for utilization of the assertiveness training materials developed. While weaknesses may be cited with regard to the assessment instruments utilized, the results of this study point to strengths in the training materials for providing a structured, systematic approach for addressing inappropriate social skills behaviors. The deafness rehabilitation professionals utilizing the training package reported utilization of the concepts presented even beyond the course of the research project and expressed their relief to have access to such formal training materials. Finally it should be emphasized that the structured assertiveness program should serve as a "first step" in remediating the social skills difficulties presented by many deaf clients. Such a structured, proactive measure should serve to lay groundwork for a more individually focused program that is tailored to the specific needs of clients that are being served.

GOAL SETTING SKILLS TRAINING

The ability to establish goals and plan for their implementation has ramifications for numerous spheres of an individual's life. This is particularly true for employment and personal/social functioning as success in these spheres of living depends heavily upon the individual's ability to establish goals and act to carry them out. Hearing-impaired adolescents and young adults, however, may be at risk for the development of maladaptive goal setting skills. In a recent article, White (1982) identified several "areas of needed improvement" in hearing-impaired adolescents as reported by educators. Among the areas most urgently in need of improvement were an awareness of one's goals and developing the ability to make sound decisions.

Several hypotheses exist for explaining why hearing-impaired adolescents and young adults may be hindered in the development of their goal setting skills. Language deficits may be involved in this situation. If adolescents or young adults do not possess the linguistic ability to express needs, desires, and feelings, then their behavior may likely be characterized by a

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high degree of impulsivity; a behavior that clearly mitigates against goal setting and problem solving skills (Harris, 1978). Meadow (1976) has additionally suggested that language deficits serve to limit the individual's ability to delay gratification and may therefore hinder efforts to teach a "work ethic" motivated by long-term rewards. Language deficits have also been found to be related to rigidity. An individual with inadequate language development may learn and adopt one basic set of rules and strategies for dealing with the world that is then utilized consistently without regard to the unique aspects of a particular situation.

Another related explanation for the reported poor ability of hearing-impaired adolescents to utilize appropriate goal setting skills is that of "psychocultural" or social learning deprivation (Meadow, 1976). That is to say, these adolescents may not have been exposed to the variety of input and feedback available to hearing adolescents within our culture. Similarly, Levine (1963) noted that deaf persons manifest a cultural deprivation that she believed was a result of failure on the part of parents, teachers, and other significant persons in the deaf individual's life to provide the information and experience necessary for the development of skills for successful life adjustment including the ability to recognize, develop and strive to attain personal goals.

Goal Setting Skills Training (GSST, G. Long, 1986) was developed in response to these needs. This package uses a systematic group counseling experience to facilitate individuals' abilities to establish goals for themselves and develop plans for their implementation. As such, it targets the "receiving" and "processing" components of the feedback loop theory of social skill identified earlier (Wallace et al., 1980). Group participants are taught the necessity of setting goals (a receiving skill) and how to identify and choose among various response strategies to meet their goals (a processing skill).

The GSST curriculum was derived from Personal Achievement Skills training (PAS, Means & Roessler, 1976; Roessler & Means, 1976). This original program teaches goal setting, communication, problem-solving, and behavioral self-control skills that can be used to augment psychosocial adjustment services in rehabilitation. Prior studies have documented the effectiveness of the comprehensive PAS program in facilitating self-reported increases in goal setting behavior and goal attainment with general rehabilitation clients (Roessler & DeWeess, 1975) and with visually handicapped persons (Roessler, 1978). In addition, Roessler, Cook, and Lillard (1976) found that PAS participants demonstrated gains in self-ratings of their life perspective, vocational and interpersonal maturity, vocational functioning, and goal attainment.

The development of GSST involved several programmatic adaptations and modifications of the PAS component on goal setting skills. The resulting program included modifications in the language used, organization of the training into 10 specific curriculum activities, and changes in the assessment measures. In addition to simplifying the language used in the training materials, a number of examples were developed to highlight deafness-related issues in an effort to increase the intervention's realism and impact.

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The GSST program was divided into two major phases, goal definition and program development. The first five curriculum activities focused on goal definition and the second five focused on the behavioral specification of goals and program development for goal achievement.

Goal Definition. The emphasis within goal definition activities was to facilitate group participants' awareness of the multitude of potential goals available to them in their daily lives (e.g., going to a movie, reading a book, obtaining a good job, going to college) and subsequent choice of a goal that is important to the participant. Emphasis was placed upon making goals behaviorally defined, observable and therefore capable of measurement. If participant goals are not behaviorally defined then the subsequent plan of action (i.e., program development activities) is doomed to failure. To ensure that goals are unambiguous they must be behaviorally and situationally defined with a stated time limit. For example, if an individual stated that he or she wanted to be "less critical" a problem arises as to the exact meaning of this goal. Where does the individual want to be "less critical." To whom? By when? This goal might be better stated as "to make four complimentary statements a day to my friends and family by October 9th."

Program Development. The second major component of GSST, program development, is designed to help participants develop and select effective responses to accomplish their goals. The essence of program development involves identifying a behavioral goal and specifying performances required to reach that goal. After defining a behavioral goal, the participant completes the remaining program development responsibilities by a) specifying steps, behaviors, or performances involved; b) estimating deadlines for each step; and c) projecting the anticipated results from each step.

Implementation of program development involves a six-step process. Initially, participants are taught that a program is similar to a game plan of things they will do to achieve a goal. Following this, the rules they should follow to develop a program and achieve their goals are:

Step 1: Behaviorally define the goal
Step 2: Brainstorm ideas
Step 3: Put the behaviors in steps from least to most difficult
Step 4: Go back through the list of steps. Revise and refine the steps. Modify the steps so that each step is slightly more difficult than the previous step. Leave out any unnecessary steps. Make the last step your goal.
Step 5: Set a reasonable deadline for each step.
Step 6: State how many times you will practice each step.

Training in Goal Setting Skills Training thus proceeds in a sequential fashion wherein participants master the skills of goal definition prior to learning how to develop a program for goal achievement.

Research Conducted With Goal Setting Skills Training

The GSST curriculum was evaluated by RT-31 using a simple pretest/posttest control group design with three groups of hearing-impaired adolescents and

young adults in two different settings (i.e., Arkansas School for the Deaf and the Hot Springs Rehabilitation Cen:-r in Hot Springs, Arkansas). At the Arkansas School for the Deaf two separate groups were conducted. The first group was composed of high school juniors within the school's gifted and talented curriculum. The second group included seniors within the school's general vocational/academic track. The group conducted at the Hot Springs Rehabilitation Center included hearing-impaired high school graduates who were involved in the Center's work adjustment program.

To evaluate the effectiveness of the GSST curriculum, four measures were used: the Meadow-Kendall Social/Emotional Adjustment Inventory for Deaf Students, a self-esteem scale, and two measures of goal setting and problem-solving abilities developed specifically for this study. To ensure that participants understood the assessment measures all instructions and questions were communicated to them via their primary communication mode (typically manual communication). In addition, assessment instructions were modified to fit the vocabulary and background of the subjects.

Research Results and Discussion

The preliminary analysis of outcome data indicates that this technique appears most suited to those individuals at the higher end of the continuum with respect to language development, intelligence, and reading ability. Specifically, only those adolescents in the gifted and talented curriculum classes at the Arkansas School for the Deaf exhibited statistically significant change in their abilities to establish goals and develop plans in response to problem situations. This group possessed an average IQ of 120 and reading level of 7.7 as measured by the Stanford Achievement Tests. In contrast, the participants in the remaining two groups were statistically average for hearing-impaired adolescents with a mean IQ of approximately 101 and reading levels of third grade.

The lack of apparent improvement found for the "lower functioning" participants may likely be attributed to the insensitivity of the assessment measures. In other words, the participants may have improved in their goal setting abilities and yet the assessment measures were unable to detect this change. It appears more likely, though, that participants with lower general functioning levels may have found this intervention too abstract and verbally laden. Support for this argument is found in a study which evaluated the comprehensive Personal Achievement Skills training curriculum with lower functioring clients at a general rehabilitation center (Roessler, Hoffman, & Garber, 1980). They found that these clients (many with IQs below 70 and reading levels below fourth grade) did not derive the same type of benefits found in prior investigations of the effectiveness of PAS training. They also hypothesized that the curriculum may be too abstract and need to include more action oriented activities to gain maximum impact with this group.

A major weakness of the GSST curriculum, as previously stated, is that the content may be too abstract and verbally laden for the majority of clients for whom it was designed. Many individuals learn most effectively when instructional content includes both diadactic/discussion material and action oriented practice including role-playing, benavioral rehearsal, in vivo practice, etc.

The combination of instructional strategies encourages ar. intellectual under-
standing as well as practice in performing the "learned" material. As
currently developed, the Goal Setting Skills Training curriculum emphasizes
the former with little attention to actual implementation of learned skills.
As preliminary analyses indicate, an emphasis on intellectual discussion may
only be of benefit to those hearing-impaired individuals who function at the
higher end of the continuum with respect to intelligence and language develop-
ment.

As a positive contribution, the GSST curriculum was found to encourage
future pl nning. Participants are introduced to the concept that they can
influence their future goals and activities by taking an active role in
planning for their implementation. Detailed strategies are presented
regarding how to best develop plans for attaining one's goals. Participants
learn how to generate alternatives and rank order them in terms of their dif-
ficulty. This strategy allows them to attain smaller goals in the process
obtaining their ultimate objective.

SUMMARY AND CONCLUSIONS

This chapter reviewed the development and evaluation of two social skills
training curriculum developed for use with hearing-impaired adolescents. The
two packages included The New Assertive You (N. Long, 1986) and Goal Setting
Skills Training (G. Long, 1986), both of which were shown to be moderately
effective in producing changes in target behaviors for some clients. One of
the stronger findings of these studies involved the usefulness of the proce-
dires as perceived by the practitioners who implemented the training. Rather
than being forced to rely on their own resources durl, 1 training, the packages
provided structure that helped focus content and activities in the group.
Despite these data, it would appear that a number of questions remain
unanswered in regard to these methods. Are the moderate results due to inade-
quacies in the measures used to evaluate the training packages? What groups
or subgroups of deaf persons are the materials best suited for? Are further
activities and exercises needed to reduce the more abstract group discussions
of content and to assist clients in actively translating these ideas into
their lives? Will clients use the skills they have learned during training
and remember them over time? Will these skills have any impact on the clients
perceived quality of their lives? Clearly, more data are needed to answer
these questions. However, it does appear these packages are potentially use-
ful strategies for use with deaf clients, especially as a starting point that
leads to a more individualized program that builds from the goals and concepts
identified and taught.

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ASSESSING THE LANGUAGE COMPETENCE
OF DEAF ADOLESCENTS

MIMI WHEIPING LOU

This paper describes a measure designed to assess the
lInguistic and communicative competence of deaf adolescents
and adults without regard to the particular language
variety, mode, and/or unique intermixing of these which may
be used by a deaf individua'. This conversaticn measure of
lInguistic, communicative competence was used In a study
examining the interrelationships among lInguistic, cogni-
tive, and social functioning for a grour of deaf ado-
lescents. The findings from this study are used to discuss
the reliability and validity of the measure.

It Is accepted almost as a truism In the field that language competence
p.ays the central role In the d /elopment of prelInguaI deaf IndivIduals, and
that language difficulties underlie the other difficulties experienced by
these IndivIduals In all areas, IncludIng cognItive-academic and social-
emotional. What Is surprIsIng Is the paucity of measures available to assess
the general language and communicative competence of the prelIngual deaf.
This paper describes one such measure developed to evaluate the language com-
petence of a group of deaf adolescents without regard to the particular
language variety, mode, or unique combination of these that are used by a deaf
IndivIdual.

This measure was developed for a specific study, the adolescent round of a
longitudinal study of a group of prelIngual deaf adolescents. At the time tne
measure was conceIved, a review of available language measures under use for a
deaf population IdentifIed many measures for assessing English language c .-
petence; few, but no generally accepted measures for assessing competence in
American SIgn Language; no measures to assess competence In any of the other
languag' arletIes falling between ASL and EnglIsh; and no measures assessing
langLage competence when a combInation of language varIetIes and mode choices

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were used. The situation in terms of language use by the prelingual deaf population was in striking contrast to this. While all deaf adolescents and adults have received formal Instruction only in the English language during the course of their education, including the two-thirds of deaf students enrolled in Total Communication programs in the 1970's, nevertheless, three-quarters of the prelingual deaf adult population were said to use ASL. Given the history of extensive English instruction and no formal ASL instruction, it was and remains likely that the great majority of the prelingual deaf adult population actually uses some language variety falling within the bounds of what is called Pidgin Sign English or Pidgin ASL. In any case, if the language competence of such a mixed language population were to be appropriately assessed, clearly, a new language measure was required.

THE INTERVIEW[1]

The instrument which we developed to be a "language-independent" or "language-fair" measure of communication and language competence is based on an interview with the subject (see interview protocol in the Appendix). The interview is structured to follow a conversational format, with both inter-viewer and interviewee taking turns asking questions of the other. The job of the interviewer is to make the interviewee feel comfortable "chatting" in this situation. Thus, the interviewer him/herself must feel comfortable, at ease, and fluent using any of the language varieties and mode combinations preferred by the interviewee, and must be encouraging of the interviewee to communicate in whatever fashion best suits that individual.

In content the interview is structured to cover familiar ground, rather than question the interviewee about topics that s/he may know little about. This is because the measure is designed to evaluate best communication skills, rather than level of knowledge or thinking. We can more correctly expect, then, that limitations in what an individual expresses reflect restrictions in their ability to communicate rather than lack of knowledge. The interview is also designed to tap a range of language functions. Thus, each individual is asked to describe, explain, tell an anecdote. offer an opinion and justify it, argue, and to question. The interview is constructed to elicit a range of g'ammatical constructions, from simple listings and phrases through possibly very complex sentences. Each individual is asked to tell about an accident or a funny anecdote as a way to elicit language which has been previously rehearsed and organized. After all, it is rare that the story of an accident has not been told over and over again. The last section of the interview about rules asks the students to present their arguments in favor of changing a rule of their choosing as if they were arguing with their parents or teachers or school principal. This part of the interview offers the oppor-tunity to use a more formal code if the student might wish and is able to do so.

SCORING[2]

There are three major scales for scoring the interview: Communicative Competence, Linguistic Competence, and Organizational Ability. The Scale of Communicative Competence includes four separate subscales:

1) Comprehension: Quantity of Information Understood by Subject
2) Production: Quantity of Information Understood by Evaluator
3) Production: Ease in Understanding Subject
4) Fluency

The Linguistic Competence Scale also includes four separate subscales:

1) Grammar Usage: Correctness
2) Grammar Usage: Range
3) Vocabulary: Correctness
4) Vocabulary: Range

The Scale of Organizational Ability is a single scale, but evaluation of this includes a consideration of the following aspects: cohesion, pertinence, logic, and elaboration.

While the Communicative Competence Scale evaluates communication at the level of the conversation, the Linguistic Competence Scale evaluates communication at the sentence and word level, and the Organizational Scale evaluates at the paragraph or topic level. All the ratings are made on the basis of four-point scales, with a "1" indicating many errors or problems, or a restricted range, up to a "4" for no problems/errors, or a broad range. Two samples of the four anchor points for different subscales are presented in Table 1.

Evaluators are asked to first give a gross score, i.e., a "1," "2," "3," or "4." This forces the raters to make a decision whether the subject falls into the better end or the lower end of each subscale. After the forced assignment of a gross score, evaluators are allowed the assign a fine score, if desired, which includes points midway between the anchor points.

There is another .ating scale which is used in the scoring, although this scale is descriptive rather than evaluative. This scale describes where the interviewee's language falls on the ASL – English continuum:

1. This person is using ASL. There is very little or no English.

2. This person is using mostly *ᴿ'., but there is some very obvious English mixed with the ASL.

3. This person is using a mixture of ASL and Eng.ish. It is difficult to say which language the person is using.

4. This person is mostly using English, but there is some very ASL mixed with the English.

5. This person is using English. There is very little or no ASL.

Please note that the anchor points have nothing to do with how well the person uses either ASL or English, which should be captured in the evaluative rating subscales of Communicative and Linguistic Competence.

TABLE 1

Sample Anchor Points

Communicative Competence: Fluency

4. No hesitations; person is totally at ease signing/speaking.

3. A few hesitations; person is generally at ease signing/speaking.

2. Many hesitations; person has noticeable difficulty in flow of com-
    munication.

1. Many hesitations; responses few and short; person is unable to carry on
    any kind of extended conversation.

Linguistic Competence: Range of Vocabulary Usage

4. Displays a broad range of varied vocabulary items.

3. Generally displays an adequate range of voca'ilary items.

2. Vocabulary knowledge is somewhat limited. Lots of repetition of similar
    vocabulary items.

1. Only uses basic limited set of vocabulary items. There may be some dif-
    ficulty in communication because of this.

There were originally two other subscales included in Linguistic
Competence, which should be mentioned. These were scales to rate the
"phonological" aspects of each individual's speech or sign production: one
scale to evaluate correctness of sign/speech production, and one to evaluate
the clarity of sign/speech production. The six subscales of the Linguistic
Competence Scale thus evaluated the three aspects of language: grammar,
vocabulary, and phonology. The decision to drop the two "phonological"
subscales was later made, however, because we felt that these were "unfair" to
the oral students and, thus, ran counter to our original aims in developing a
language- and mode-fair measure. While it is to be expected that the speech
of prelingual deaf individuals will be hurt by the profound hearing loss, the
same is not true for the signing of prelingual deaf individuals with no other
majoi disability. If quality of sign or speech production were to be com-
pared, then, for a prelingual deaf population, we could expect the speech pro-
duction ratings for oral deaf to be depressed compared to the sign production
ratings for those using a manual system. Although phonological aspects are
important for effective communication, we decided to drop these two subscales
because we could not find a way to equate ratings between the oral and manual
groups.

APPLICATION OF THE MEASURE

This language-fair measure of communicative competence has been used in a
study of 39 prelingual deaf adolescents, ranging in age from 15-17 years. The

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application of the measure In this study will be described and the findings from this study will be discussed as evidence supporting the validity and reliability of the measure.

The students In the study were all participants in a longitudinal begun in 1969 by Schlesinger and Meadow (1972), when the children ranged in age from 2 1/2 - 4 years. At the time of the first round, the 40 original subjects met the following criteria for inclusion in the study: profoundly, prelingually deaf (with a hearing loss of at least 80 dB In the better ear); no other major diagnosed handicap; living with both white, English-speaking parents; enrolled In preschool; judged to be not retarded or slow by their teachers; and not a twin. Four of the children were enrolled In Total Communication preschool programs at the time of this first round, with the other 36 children enrolled In oral preschool programs. At the time of the adolescent round, 39 subjects returned to participate again. Of these students 13 were still enrolled In oral programs, while 12 attended public day programs holding a Total Communication philosophy, and 14 were enrolled In public residential programs, presumably with at least some exposure to ASL. They were In grade levels ranging from 7th through 11th.

One of the aims of this round of the study was to examine the Interrela-tionships among different areas of development - linguistic, cognitive, and social - for this population. Therefore, each adolescent with at least one parent came to the University of California Center on Deafness In San Francisco for two full days of assessment. The list of measures and tasks used with each subject can be found In Table 2.

The communicative competence conversation measure was scheduled for the early afternoon of the first day of assessment. This meant that the students were still relatively fresh, but, at the same time, had spent enough time with the research team, particularly the Interviewer, to feel comfortable. Each Interview lasted approximately 45 minutes, and was videorecorded on split screen with one camera focused on the Interviewer and one on the adolescent. The Interviewer was the hearing daughter of deaf parents. She held a Comprehensive Skills Certificate with over 16 years professional Interpreting experience. She had also attended workshops on both SEE II and oral interpreting. She also had over 15 years working with deaf students, mostly In a residential school setting, and was presently completing graduate work for a Master's degree In counseling psychology. During the conversation, tne Interviewer tried to use a language variety, mode, and style of communicating which the adolescent had shown comfort with over the activities and scheduled breaks of the preceding morning.

Three excerpts from each videotape were copied for scoring purposes. These were the sections describing an accident, telling something about some given topic (e.g., pets, sports, T.V., books), and offering an opinion and discussing a serious topic such as gun control. These excerpts ran a total of about 15 - 20 minutes. Each was scored by a rater who was a professional Interpreter, holding a CSC for over 8 years, and working In the field of Interpreter training for 5 years.

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TABLE 2

List of Measures

A. Communicative Functioning

    1. Conversation Measure, including scales for:

        a. Linguistic Competence
        b. Communicative Competence
        c. Organizational Ability

    2. Reading Comprehension (Stanford Achievement Test)

    3. Written English Syntax

    4. Story Recall

  *5. Language-Mode Familiarity (ASL, Signed English, SEE, Oral English)

  *6. Speech Intelligibility

B. Cognitive Functioning

    1. Intelligence, including:

        a. WISC-R Performance Scale
        b. WISC-R Verbal Subscales: Information, Similarities, Comprehension

    2. Reasoning (Piaget's Pendulum Problem)

  *3. School Achievement (Grades)

C. Psychosocial Functioning

    1. Self-Image (Meadow Pictorial Scale)

    2. Socioemotional Adjustment (Meadow-Kendall Scales)

    3. Impulsivity (Rorschach, Draw-a-Line, Porteus Mazes)

    4. Quality of Mother-Adolescent Interaction

*   not included in present analyses

RELIABILITY

Two other evaluators rated a subset of 10 of the 39 interviews independently. One evaluator was, in fact, the original interviewer herself, though she made these evaluations over a year after conducting the last interview for the study. She rated a subset of 10 interviews selected at random, including

adolescents who preferred using oral English, those preferring to use some system of manual English, and those preferring ASL. The interpreter agreement between these two evaluators for the separate subscales ranged from .83 - .97. A third evaluator rated another subset of 10 interviews which were selected at random from among only those students relying solely on a manual language system. This judge was a hearing-impaired native ASL user who also taught ASL at a college level. The interrater agreement between this second reliability rater and the original judge ranged from .58 - .76 on the communicative competence subscale ratings, and from .52 - .81 on the linguistic competence subscale scores. Different scales for the evaluation of organizational ability were used by these two judges, so the level of interrater agreement on this dimension cannot be calculated.

VALIDITY

There are two aspects of validity which are of significance. One is the issue of whether this measure does assess linguistic, communicative skills. If the answer to this is affirmative, then the second issue is whether the measure is actually "language-fair" in the sense of evaluating linguistic, communicative skills without regard to the particular language variety, mode, or unique intermixing of these used by the individual communicator. These two issues of validity will be discussed separately.

The findings regarding the interrelationships among the variety of measures used in this round of the study suggest that this conversation measure does, in fact, assess linguistic, communicative skills. The strength of the relationships between the three conversation scales of Linguistic, Communicative, and Organizational Competence and the other language, cognitive, and social measures analyzed can be seen in Table 3.

It is clear that the three scales taken from the conversation measure itself are highly interrelated, with r ranging from .46 - .63. Furthermore, these three scales are also related to the other language measures taken: reading comprehension, written English syntax, and story recall. The relationship of Organizational Ability to these other language measures is particularly strong, with correlations of about .55; followed by the relationship of Linguistic Competence to these three other measures, with correlations of about .40. What is even more striking are the relationships between the three conversation scales and the three verbal subscales used from the WISC-R. Again, the strongest relationships tend to be those between Organizational Ability and the WISC-R verbal subscales, particularly the Similarities and Comprehension subscales. Again, the relationships between Linguistic Competence and these cognitive subscales are also quite strong, while the relationships between Communicative Competence and these measures are noticeably weaker. Level of reasoning as assessed with Piaget's pendulum problem is also clearly related to both the Linguistic Competence and Organizational Scales of the conversation measure.

At the same time that the relationships between the conversation scales and the other language measures and the verbal cognitive measures are quite strong, the relationships between the three conversation scales and performance I.Q. and the social measures are noticeably weak. Out of these last

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TABLE 3

Relationship of Conversation Measures to Other Measures

	Ling. Comp	Comm. Comp	Organ
Other Language Measures			
Communicative Competence	.63**		
Organizational Ability	.46**	.58**	
Reading Comprehension	.40*	.26	.54**
Written English Syntax	.39*	.36*	.56**
Story Recall	.40*	.38*	.55**
Cognitive Measures			
WISC-R Performance Scale	.05	−.08	−.16
WISC-R Information	.41**	.29	.44**
WISC-R Similarities	.50**	.34*	.61**
WISC-R Comprehension	.50**	.33*	.64**
Pendulum Problem	.34*	.10	.41**
Social Measures			
Meadow-Kendall Social Adjustment	.31	.29	.29
Meadow-Kendall Emotional Adjustment	.36*	.20	.20
Meadow-Kendall Self-Image	.17	.12	.28
Meadow Self-Image	−.12	−.19	−.02

measures, only the relationship between linguistic competence and the Emotional Adjustment Scale of the Meadow-Kendall measure is worth noting.

Thus, it appears that whatever the conversation measure is assessing, it is closely related to verbal and verbal-cognitive skills, while being unrelated to nonverbal cognitive skills and social-emotional variables.

The question remaining, then, is this: Is this measure of linguistic communicative competence fair regardless of what particular language variety, mode, and/or combination of these that a deaf individual chooses to use for the assessment procedure? There is some evidence from this study suggesting that the answer is yes. If the adolescents are divided according to the language variety used for the conversation measure, then 18 students were rated as using English only (or "E") on the ASL-English scale, while 21 would fall into a mixed group of individuals using anything from ASL to almost-pure-English-but-not-quite (i.e., a rating of "A"-"D" on the ASL-English dimension). A comparison of these two subgroups, the English-only and the Mixed, shows no significant differences in mean scores on any subscale of the Linguistic Competence, Communicative Competence, or Organizational Ability Scales. This lack of difference could be interpreted in at least two ways. The first possibility is that the language measure is fair and no differences can be found in groups according their language of choice. A second

possibility is that the measure unfairly inflates the scores of subjects using one language variety. In other words, although it is actually the case that the users of one language variety are more linguistically competent than the users of the other language variety (or varieties), nevertheless, somehow the application of the conversation measure unfairly equates the performance of the two groups. This second possibility, however, seems less likely given the findings regarding the patterns of interrelationships found between the conversation scales and the other language and verbal-cognitive measures, which support the validity of the conversation instrument.

CONCLUSION

The conversation measure described has been used effectively with a group of deaf adolescents who represent a broad mix of language backgrounds and present usage. It was developed in order to evaluate the linguistic, communicative competence of these students without regard for the particular language variety, mode, and intermingling of these which the student might use. Evidence has been presented suggesting that the measure does, in fact, evaluate skills which are at least closely related to other language and verbal-cognitive skills. Evidence supporting the suggestion that the measure is "language-fair" has also been presented.

At the same time, much work remains to be done in the future if this instrument is to be broadly accepted for research and educational and clinical application as a truly valid and "language-fa'." measure of language and communication competence. One necessary step is the broadening of the study sample to include deaf adults, as well as deaf adolescents and adults who are native ASL users. The inclusion of a broader range of language experience and background for the population studied may well result in the refinement of anchor points for the various subscales of the Linguistic Competence, Communicative Competence, and Organizational Ability Scales. Ultimately, the cohesiveness and the interrelationships among the various subscales must be examined as well using factor analytic techniques. In the meantime, however, this conversation measure represents an approach to be tried when the language competence of deaf individuals must be assessed independently of their own preference for a particular language variety, mode, or unique combination of these.

FOOTNOTES

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Conversation Language Measure: Interview Protocol

Introduction

We're going to talk a little, so we can learn more about each other.   I'm interested in you and what you like to do.   So I'll ask you some questions, and you can ask me some questions If you want, O.K.?   If you don't feel like answering a question, th t's O.K., you don't have to.   Do you want to ask me anything before we start?

House

Let's start by your telling me about your house.   What does your house look like?   Can you describe it to me?   (Outside, inside).   What does your room look like?

That's different from my house.   My house is . . .

What do you like to do when you are home?

Activities

Do you have something that you are really good at doing, an expert at? Can you tell me how to do that?

Have you ever ..ad a really bad accident?   Can you describe that to me?

Tell me what happened?

(Or, describe the funniest thing . . .)

Topic

O.K., as a change, I'm going to give you a topic and you talk a short time about it.   You can give me a topic, too.   We can take turns.   Do you want to start first, or shall I?

cats or dogs, pets	friends	sports
ESP	T.V.	books
babies	candy	

Serious Topics: Personal Opinion

I'd like to ask your opinion on a couple of topics.   (Choose two only). You heard about President Reagan and 'he Pope and President Sadat being shot? What do you think should be done to prevent people from being shot (gun control)?

Do you think women should be included in the draft?

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Do you think deaf people should be allowed in the army?

Rules

Someday you'll probably be a parent and have children, too, right? Well, I'd like you to imagine now that you are a parent and that you have a child that is the same age as you - How old are you now?

O.K., your child is now ___, same as you. What kind of rules would you make for them? Why do you choose those rules?

How about at home (or school) for you. What kind of rules do your parents (teachers, principal) have for you? Do you agree with those rules? Why (not)? Are there any (or Which rule) would you like to change? O.K., let's say that your parents are willing to listen to your reasons to change that rule. What would you say to them to convince them to change that rule?

GENERALIZATION STRATEGIES FROM THE PATHS PROJECT FOR THE PREVENTION OF SUBSTANCE USE DISORDERS

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The present paper presents an extension of the PATHS Curriculum as a method for preventing the development of Substance Use Disorders in deaf adolescents. Following a review of Substance Use Disorders in general, substance abuse and related issues in the deaf population are discussed. The theoretical concepts underlying the PATHS Curriculum are then reviewed, a brief account of the curriculum is provided, and some of the major research findings are summarized. Finally, an adaptation of PATHS for preventing substance abuse is discussed and two transcripts of actual lessons are provided.

Two years ago, the companion to this paper was presented (Greenberg, Kusché, Gustafson, & Calderon, 1985), in which the PATHS Curriculum, a program designed to improve self-control, emotional understanding, social awareness, self-esteem, and interpersonal problem-solving skills in deaf elementary school-aged children was first introduced. In the first paper, the theoretical background behind PATHS and the first year outcome results of the PATHS Project were also described. In the present paper, an extension of the PATHS Curriculum as a method for preventing the development of Substance Use Disorders in deaf adolescents will be discussed. The present paper will begin with a general review of Substance Use Disorders followed by a discussion of substance abuse and related issues in the deaf population. The theoretical background of the PATHS Curriculum will then be reviewed, a brief description of the curriculum will be provided and the major research findings to date will be summarized. Finally, the adaptation of PATHS for preventing substance abuse will be discussed and two examples of actual lessons will be provided.

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SUBSTANCE USE DISORDERS: DEFINITIONS, FEATURES, COMPLICATIONS, AND PREVALENCE

In the third edition of the Diagnostic and Statistical Manual of Mental Disorders (1980), or DSM-III as it is more generally called, Substance Use Disorders are diagnosed on Axis I, which classifies these types of conditions as clinical syndromes. DSM-III is the diagnostic handbook used by the majority of mental health service providers in this country. In other words, the majority of clinicians in this country agree that Substance Use Disorders are clinical syndromes for which individuals need treatment.

Substance Use Disorders are defined in DSM-III as a diagnostic category which "deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system" (p. 163). DSM-III further distinguishes between Substance Abuse and Substance Dependence. Substance Abuse includes a "pattern of pathological use, impairment in social or occupational functioning due to substance use, and minimal duration of disturbance of at least one month" (p. 163). Substance Dependence, on the other hand, includes "Tolerance or withdrawal" (p. 163). For alcohol and cannabis dependence, "a pattern of pathological use of impairment in social or occupational functioning is also required" (p. 163). The five substances associated with both abuse and dependence include alcohol, barbiturates or hypnotics, opioids, amphetamines, and cannabis. The three additional substances related only to abuse include cocaine, PCP, and hallucinogens. Tobacco is associated only with dependence.

Personality disorders and disturbance of mood are often present in addition to substance use and may be intensified by it. For example, an individual may use alcohol or drugs in an attempt to treat symptoms of anxiety or depression. In a temporary sense, this form of "treatment" generally does alleviate mental pain, and so is strongly reinforcing in the short run. In the longer run, however, the individual's symptoms may be intensified. Depressive symptoms are therefore frequently noted as complications of Substance Use Disorders, and the high rate of suicide by individuals with Substance Dependence is partially accounted for by these associated depressive symptoms.

Substance users frequently evidence a deterioration in their general level of physical health over a period of time. Organic Brain Syndrome, for example, is a complication frequently found with all types of Substance Use Disorders. Physical complications associated with chronic Alcohol Dependence include cirrhosis, hepatitis, gastritis, peripheral neuropathy, and increased risk and seriousness of pneumonia, heart disease, tuberculosis, and neurological disorders. Serious physical disorders most commonly related to Tobacco Dependence include emphysema, peripheral vascular disease, coronary artery disease, and a variety of cancers. Use of other nonprescription drugs is similarly related to various physical disorders.

Birth defects (e.g., fetal alcohol syndrome), automobile accidents, industrial injuries, poor employment opportunities, and a high educational drop out rate are among the many "side effects" of substance abuse. "When a Substance Use Disorder begins early in life, it is often associated with

failure to complete school and a lifelong pattern of low occupational achievement" (DSM-III, 1980, p.   167).   Millions of family members also suffer intense emotional pain due to substance abuse by children, parents, and spouses.

Alcohol Abuse and Dependence generally appear when individuals are in their 20's, 30's, and 40's, typically within the first five years after regular drinking has been established.   "Heavy drinking in adolescence (before age 16) s particularly likely to be associated with later problems" (p. 169). Disorders involving Cocaine, Cannabis, Amphetamines, Hallucinogens, Opioids, and PCP commonly begin in the late teens and 20's.   The two major patterns of barbiturate abuse involve middle-class, middle-aged females whose disorder begins with the abuse of perscribed medication and males in their teens or early 20's who begin using illegal sedative or hypnotic substances in the peer group environment.   Tobacco Dependence usually begins in late adolescence or early adulthood.   Among teenagers, males and females are approximately equally affected by Tobacco Dependence; in the adult population, males used to show a much higher prevalence rate than women, but this pattern appears to be changing.

Within the overall U.S. population, Substance Use Disorders are common, especially those related to alcohol and tobacco.   According to DSM-III, approximately 16% of the U.S. population reports having experienced some problem associated with alcohol within the past three years and approximately 4% report serious problems.   The prevalence of Tobacco Dependence is unknown, since an individual must express a desire to stop smoking and an inability to do so or must evidence a serious physical disorder known to be aggravated by tobacco use before Tobacco Dependence can be diagnosed.   However, since approximately half of all smokers express a wish to stop smoking along with an inability to do so, and because serious physical disorders exacerbated by tobacco use are common, it is obvious that Tobacco Dependence is widespread. Other types of substance use are less common, but may show different prevalence rates among various populations.   For example, disorders involving Opioids are rare in the general population, but are more widespread in economically deprived urban communities.

The prevalence of Substance Use Disorders in the deaf population was unknown until very recently.   In fact, surprisingly little research exists prior to 1980 on the topic of substance use in the deaf population; denial and avoidance of this area in the past are notable.   As Steitler (1985) reported, "Chemical dependency remains a 'hidden' problem within the deaf community. Affected individuals tend to be identified and treated in the late stages of their illness" (p. 170).

We might expect to find that the incidence of substance use is higher in the hearing-impaired population, since deaf people as a group are generally less well-educated than their hearing peers, have both a handicap and a "minority group" status, tend to have difficulties with poor self-esteem, often have less opportunities for learning information related to social norms, beliefs, and health-related social issues, are sometimes delayed in their development of social-emotional understanding, and so forth (Greenberg & Kusché, in press; Kusché, Garfield, & Greenberg, 1983; Kusché & Greenberg,

1983). As noted by Watson, Boros, and Zrimec (1979), the "resulting feelings of low self-esteem, isolation, loneliness, and frustration contribute to the incidence of alcoholism among the deaf" (p. 33).

According to Steitler (1985), drug and alcohol abuse is slightly higher among handicapped individuals in general, as compared to their nonhandicapped peers. For the deaf population, recent estimates of the incidence of substance abuse varies from 7% to 20% or higher. Moreover, it is estimated that one-fourth to one-third of all mental health problems in the U.S. deaf population involve Substance Use Disorders. Scanlon (1983), for example, reported informally that of the first 100 admissions of hearing-impaired individuals to a hospital in Minnesota, almost one-third were substance abusers, and to this was added the confusing disclaimer that his group could not accept referrals directly to their substance abuse programs "unless the primary problem is mental illness" (p. 8).

Interestingly, Rainer, Altshuler, Kallmann, and Deming (1969) reported that only two deaf patients were diagnosed as having psychosis with chronic alcoholism during a seven year study, as compared to approximately one-third of the hearing patients. Whether the large discrepancy between their findings and those reported in the recent literature reflect differences in diagnostic categories, admission rates, incidence, or other factors, is difficult to discern. Without further information, these data suggest that (1) Substance Use Disorder without the additional diagnosis of psychotic disorder is likely to be somewhat more prevalent in the hearing-impaired population than is the combination of the two conditions, and (2) treatment of Substance Use Disorders in the deaf population is probably more readily available and utilized at the present time than was the case in the past. Further research regarding the prevalence of specific subtypes of Substance Use Disorders and of their prevalence in conjunction with other clinical syndromes in the deaf population is still badly needed.

SUBSTANCE USE DISORDERS IN THE DEAF POPULATION

In general, the types of substance abuse behaviors displayed by deaf individuals tend to be very similar to those demonstrated by hearing abusers (Darmsted & Cassell, 1983; Grant, Kramer, & Nash, 1983). Substance users typically deny that they have a problem and discount their need for treatment; in other words, resistance to therapy is generally quite high, and it is very difficult to diagnose a Substance Use Disorder when a client attempts to hide relevant information. This situation is often further compounded with hearing-impaired individuals because of communication difficulties. In addition, impairment in social and occupation functioning due to substance use, a major criteria for diagnosis, is often difficult to discriminate from other potential causal factors frequently associated with deafness, such as deficient education, inadequate socialization, and so forth.

Even when help is sought, Substance Use Disorders tend to be difficult to treat, and relapse rates are frequently high. Resistance and high relapse rates are likely to be even more pronounced in the deaf population for a number of reasons:

(1) In addition to the stigma and resistance generally experienced in admitting to a substance use-related problem, the hearing-impaired individual is also likely to be motivated to hide his/her difficulties because of the cultural values of the deaf community, where alcoholism and drug abuse are considered to be non-acceptable behaviors. In other words, substance abuse is generally not perceived by the deaf community as a syndrome for which treatment is needed, but rather is perceived in a black-and-white manner (a perspective which is similarly shared by a large proportion of hearing individuals): That is, you are a bad person if you have a bad habit (Adler, 1983).

(2) The deaf individual is less likely to recognize that s/he has a Substance Use Disorder, since s/he has had less access to information about this topic.

(3) If the hearing-impaired individual is aware of his/her problem, there is only a small probability that s/he will find appropriate deaf-and-substance-use services in his/her community. Watson (1983) reported that in 1981, "only ten communities provide[d] viable substance abuse treatment services for deaf clients" (p. 13). Most state hospitals and community mental health centers simply do not have the capacities for treating hearing-impaired individuals. Money for specialized treatment centers and signing mental health professionals knowledgeable in the psychosocial aspects of deafness are both scarce commodities. Steps to alleviate this problem have recently led to some improvement (e.g., Project AID – Addiction Intervention with the Deaf [1983]; Task Force on Enhancing Training for Alcoholism and Drug Abuse Services for the Deaf [1982]; Substance and Alcohol Intervention Services for the Deaf at Rochester Institute of Technology [Steitler, 1983, 1985]; the Stephen Miller House residential program for deaf alcoholics [Rothfeld, 1983]), but specialized treatment programs are still needed in most areas of this country.

(4) Many hearing-impaired individuals mistrust hearing professionals for a variety of reasons (Chough, 1983; Kannapell, 1983) and are therefore less likely to seek treatment from them.

The combination of mistrust and inadequate information regarding mental health services therefore compounds an already difficult problem in treating substance use problems in the deaf population. As Watson (1983) noted, "In the absence of personal exposure to positive 'models' of assistance for various life problems, many deaf persons often delay seeking assistance because of ignorance and/or lack of knowledge about its availability and resources until their problems have multiplied and compounded to the point of causing social or legal difficulties—leading to a referral. Usually referred by schools, family, friends, rehabilitation agency, employer, or other sources few deaf people are self-referrals" (p. 13).

(5) When hearing-impaired individuals do begin treatment, they often do so at a disadvantage as compared with hearing clients. The deaf client frequently is unfamiliar with the goals or procedures of treatment, does not understand many of the basic concepts related to therapy (e.g., the idea that talking about feelings can be helpful), and are handicapped by an inadequate linguistic knowledge of terminology typically utilized in substance abuse programs. Because of their childhood experiences of "being taken care of," deaf clients frequently expect that therapists will magically and quickly "fix" their problems for them. Many deaf individuals have not been socialized to assume responsibility for themselves, believe that only very seriously disturbed individuals are in need of treatment, and are not prepared for the fact that treatment takes active commitment, regularity, and time. As Watson (1983) noted, "Communication and language difficulties, the time required to orient deaf clients to the proper use of therapeutic services, teaching of therapeutic concepts and vocabulary, and related extraordinary service requirements usually increase the amount of time and duration of therapeutic interventions with deaf persons" (p. 15).

(6) Direct treatment only is not likely to be sufficient for deaf individuals with Substance Use Disorders. Scanlon (1983) reported that without follow-up services, all of the deaf individuals he studied who had been treated in an alcohol abuse program resumed drinking after termination of direct treatment. On the other hand, with some support service, continuing therapy, and/or related emotional support following treatment, two-thirds of the deaf clients studied continued to abstain from alcohol use.

(7) Finally, professional treatment is expensive and frequently is not covered by insurance or government subsidy in this country.

In summary, treatment for deaf persons with Substance Use Disorders is generally difficult to find, is not readily utilized by the hearing-impaired population, often is not well-suited for the needs and capacities of the average deaf individual, and is generally very costly. It would seem then, that prevention of substance abuse and dependence should be an especially high priority for this population.

THE POTENTIAL ROLE OF THE EDUCATIONAL SYSTEM FOR PREVENTING SUBSTANCE DISORDERS

Because of communication issues, schools tend to play an especially important role in the socialization process of hearing-impaired individuals: "The philosophy of teachers of deaf children has a tremendous impact on their future lives" (Chough, 1963). The school would therefore seem to be a natural and cost-effective setting for providing a substance-abuse prevention intervention program for hearing-impaired adolescents. In addition to preventing

future Substance Use Disorders, such a program could also promote the development of capacities that would facilitate the utilization of therapeutic treatment, should it be needed in the future.

Cross (1979) has suggested that drug and alcohol education should begin during the elementary school years and should focus on discussions of values, risk-taking, decision-making, and problem-solving. It has been additionally suggested that the primary objective of such a prevention program should be to help students develop a realistic and responsible attitude towards the use of chemical substances. Because values, opinions, and attitudes are largely shaped at an early age, the introduction of a prevention program during the elementary years is considered to be especially important.

Recently, a very innovative and creative teacher in Tacoma, Washington combined information related to drug and alcohol abuse with the paradigm his class had learned during the two years he had utilized the PATHS Curriculum. We were very impressed with the results we observed and felt that this technique could be expanded and utilized very effectively to prevent substance abuse among deaf adolescents. Before proceeding further in explaining this model for substance abuse prevention, however, a brief review of the goals and processes of the PATHS Curriculum is necessary.

THE PATHS CURRICULUM: WHY IT WAS DEVELOPED

The PATHS (Providing Alternative Thinking Strategies) Curriculum (Greenberg, Kusché, Calderon, & Gustafson, in press) was originally developed after several years of research and observations regarding the social and emotional development of deaf children, who, as a group, clearly demonstrate delays in social-emotional development (Greenberg, Kusché, & Smith, 1982; Greenberg & Kusché, in press; Kusché & Greenberg, 1983). Because of language barriers, most hearing parents are limited in their ability to communicate meaningfully with their deaf children. As a result, deaf children frequently receive limited explanations for feelings, roles, reasons for actions, and consequences of their own and others' behaviors. Many deaf individuals therefore grow up with an incomplete or distorted perspective of societal attitudes, norms, values, and frames of reference (Rodda, 1966). Information and perspectives that could otherwise be learned through verbal language, innuendo, and intonation are also not assimilated (Koetitz, 1976). In addition, parents of deaf children tend to rely heavily on nonverbal means for socialization (Schlesinger & Meadow, 1972), which do not allow children to develop complex evaluative understanding that is necessary for mature social adjustment. Due to this linguistic deprivation and isolation during development, deaf children become a "high risk" group for social-emotional difficulties (Meadow, 1980).

Language deprivation during development also results in information processing deficits, particularly in the ability to utilize internal speech (Greenberg & Kusché, in press; Kusché, 1985). One of the crucial tasks during the late preschool and elementary school-age years is to learn to integrate previously developed modes of thinking and feeling with the newly acquired ability to think in language-based codes. Between the ages of 5 and 7, the average hearing child shows a peak in the use of "private speech" (Kohlberg,

Yaeger, & Hjertholm, 1968). "The development o. private speech apparently goes hand in hand with the ability to inhibit extraneous motor behavior and focus attention . . . Private speech is an important means through which children organize, understand, and gain control over their behavior" (Berk, 1986, p. 42).

According to Vygotsky (1962), inner speech originates in and is stimulated by early social experience. The ability to utilize inner speech enables the child to "think" automatically (in verbal terms) about affect and to use internal speech to mediate emotional expression and release. During the preschool years, nonverbal emotional displays are increasingly replaced by language as a means of communication and as a method for learning about the world. Both Katan (1961) and Furman (1978) have similarly suggested that emotional language facilitates control over nonverbal affective expression: "Through verbalization, the ego is able to master its affects and does not have to resort to defenses like denial, avoidance, etc., to shut these affects out" (Katan, 1961, p. 187-188). Language thus plays a crucial role in emotional development, just as verbal mediation is of vital importance for memory development (Flavell, 1977) and the development of self-control and self-regulation (Luria, 1959, 1961; Meichenbaum, 1979; Vygotsky, 1962).

Because of inner speech, the hearing concrete operational child is able to interpret, mentally transform, and reconstruct reality in new ways. Moreover, through the use of internal language, the child gains conscious awareness of and control over his/her affective experiences. S/he can learn to label his/her affective schemes, think about the causes for feelings, monitor the effects that emotions have on others, gain awareness that the same situation can affect various people in different ways, learn how and when to control emotional displays, and so forth (Carroll & Steward, 1984; Harris, Olthof, & Terwogt, 1981; Gnepp & Hess, 1986; Weiner & Handel, 1985; Zelko, Duncan, Barden, Garber, & Masters, 1986). This knowledge is gradually acquired over the course of childhood, allowing the child to better master his/her affective and interpersonal life and resulting in the formal operational adolescent who can think propositionally and abstractly about feelings.

Language, then, is believed to play a crucial role in controlling behavioral and emotional responses, but only if children come to associate or link their behaviors with internalized language (i.e., learn to use language to mediate their emotional reactions). Healthy adaptation for children and adults depends on the development of propitious linkages between language, thought, emotion, and action. Through appropriate modeling, discussion, and experience, optimally-functioning children learn to accurately (1) label and monitor their emotional reactions, (2) verbally code and when appropriate communicate their emotional states to others, and (3) develop suitable plans or strategies for behavior that utilize language and thought to appropriately reach their desired goals.

As a result of socialization, hearing children become increasingly capable of demonstrating more mature forms of self-control and of utilizing higher-order cognitive processes in the service of action. While these capacities begin in their incipient forms during the preschool years, they are continually undergoing reorganization (differentiation and integration)

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throughout childhood and adolescence. Although the average hearing child progresses relatively smoothly through these phases and develops both emotional control and an internal sense of self-efficacy and competence, the hearing-impaired child frequently does not. When the development of internal speech is delayed, young deaf children cannot automatically utilize their cognitive-linguistic signal system for control of, or as a substitute for, actions; as a result, they often display difficulties with impulsive, aggressive, and/or inattentive behaviors.

Finally, deaf children frequently do not learn how to make intentional choices, to be responsible for their own actions, to set future goals, or to make plans for the future. "Many deaf children have grown up in family environments where most things were done for them. Therefore, they missed out on the basic human right to make mistakes . . . Deaf children are often cheated of the ability to learn from their experiences, as their parents and siblings, although well-intentioned, tend to overcompensate for their deafness by doing everything for them" (Chough, 1983, p. 18). Similarly, hearing professionals in the past have also traditionally made decisions for deaf children and adolescents, which has fostered a dependency that has often extended into adulthood.

The school setting is also frequently suppressive. For example, communication patterns in classrooms for deaf children are often dominated and directed by the teacher (Craig & Collins, 1970). Instead of responding to the content of communications made by deaf students, teachers often require children to repeat their messages in order to practice better grammar or to utilize better speech; with the best of intentions, these educators frequently teach deaf children that it is better not to initiate conversation.

In summary, deaf children as a group receive less-than-adequate social knowledge, demonstrate delays in the ability to utilize verbal mediation, and generally lack the skills and motivation necessary for independent problem-solving. In order to ameliorate these deficiencies, we felt that deaf children needed a curriculum specifically designed to meet their special needs.

THE PATHS CURRICULUM MODEL

The hybrid developmental model behind PATHS incorporates theories of Piagetian cognitive development, cognitive social-learning theory (Bandura, 1977; Meichenbaum, 1976), developmental social cognition (Greenspan, 1981; Selman, 1980; Spivack, Platt, & Shure, 1976), and psychoanalytic developmental psychology (Freud, 1965, 1981). Implicit in this integrated developmental model is the idea that during the maturational process, "thinking in feeling" (i.e., sensoriaffective intelligence) precedes linguistically-mediated forms of cognition. As a result, affect is an important precursor for other modes of thinking, and later needs to be integrated with other developmental functions for optimal maturation. Recent findings in the neurobiology of emotional and brain development also provide support for this model (Fox & Davidson, 1984; Harris, 1986; Hellman & Satz, 1983; Kusché, 1984).

Unlike prior social skills training programs founded primarily on behavioral or cognitive-behavioral models (e.g., contingency management, modeling, coaching, interpersonal cognitive problem-solving), the PATHS Curriculum is based on an ABCD (Affective-Behavioral-Cognitive-Developmental) approach to child mental health and education. As its name implies, the ABCD model incorporates those components that have been found to be effective in former research and additionally emphasizes two further areas of major importance that have been virtually overlooked in past work in this area: the developmental process and emotional understanding.

Based on the ABCD approach, the PATHS Curriculum utilizes a developmental approach to systematically and hierarchically integrate the teaching of self-control (Camp, Blom, Herbert, & van Doorninck, 1977; Meichenbaum & Goodman, 1971), empathy (Elardo & Cooper, 1977; Feshbach, 1978), role-taking (Chandler, 1973), emotional understanding (Kusche, 1984, 1986), and interpersonal problem-solving (Sarason & Ganzer, 1973; Shure & Spivak, 1978; Weissberg, Gesten, Liebenstein, Doherty-Schmid, & Hutton, 1980) during the critical elementary school-age years. Recognition, labeling, and understanding of emotions are strongly emphasized as crucial precursors for effective behavioral self-control and optimal problem resolution.

The 2-volume curriculum consists of 100 lessons which are built upon one another according to increasing developmental difficulty and which utilize role-playing, modeling by teachers and peers, social and self-reinforcement, attribution training, dialoguing, and verbal mediation. It is recommended that PATHS be taught on a daily basis for approximately 30 minutes each day, but the actual time spent is up to the teacher. Depending on the interests and capacities of the children, the curriculum can be completed in one or more years. Flexibility is provided to allow the teacher, with supervision, to choose the conceptual level and the pace that best fits the cognitive and maturational levels of his/her classroom.

Learning is promoted in a multi-method manner through the combined use of the visual, verbal, and kinesthetic modalities. Stories and activities are included to enhance motivation and skills in reading and language arts, and numerous pictures and photographs are included to visually illustrate the stories and concepts. Extensive generalization techniques are included to expedite the dynamic relationship between cognitive understanding and real-life situations. Based on research findings, additional components are also embedded within the curriculum to enhance cognitive skills which frequently go unaddressed in the classroom setting such as memory encoding (Flavell, 1977), hierarchical classification skills (Rosch, Mervis, Gray, Johnson, & Boyes-Braem, 1976), and logical reasoning skills (Piaget & Inhelder, 1973).

Because PATHS utilizes emotional and social content to facilitate the acquisition of cognitive processes, the material is of special interest and relevance for children. PATHS emphasizes enjoyable participation on the part of children, thus enhancing the probability for acquisition of both content and process. We have found that both deaf and hearing children are highly motivated to communicate with adults when the topic at hand is relevant and affectively meaningful to them.

PATHS time is designed to be a very special time of day. In order to maintain a strong affective identification with the content and activities, techniques are utilized to emphasize the active and creative roles of the children, in contrast to the standard didactic, passive learning environment often found in the classroom. Teachers are encouraged to remain nonjudgmental during PATHS Time so as to facilitate exploration of ideas and beliefs. For example, rather than respond with, "That's a bad (or good) idea." the teacher might say, "That's one idea or one way to think about it. What is another idea?" We also strongly recommend that teachers refrain from correcting grammar or speech during PATHS Time, as the focus of PATHS involves the facilitation of open communication through dialoguing and social interchange.

PATHS consists of three major content areas. The first major focus of the curriculum is the development of self control and problem identification. Self-control training begins during the first week and consists of an adaptation of the Turtle Technique (Schneider & Robin, 1978). which provides children with a behavioral technique for maintaining self-control. The children are taught that "doing Turtle" is one way of coping with a problem. Once they are able to calm down and think about what is going on in emotional situations, they are then ready to utilize other more cognitively-laden problem-solving techniques. Thus, this section of the curriculum prepares children to develop or improve the ability to monitor their internal states and utilize verbal mediation to inhibit actions.

The second major focus of the curriculum consists of teaching emotional understanding. Concepts necessary for understanding emotions and for logical reasoning and problem-solving (Spivack, Platt, & Shure, 1976; Spivack, & Shure, 1974) are introduced and illustrated. The children are not simply taught vocabulary "words," but rather are introduced to the subtle connotations and nuances connected with their usage. To enhance generalizability throughout the classroom day, each child keeps his/her personal "Feeling Box," containing his/her own set of "Feeling Faces" which can be interchangeably inserted into his/her "Feeling Strip" containing the words, "I feel _____." Feelings can thereby be easily communicated at any time. The teachers and aides are encouraged to have their own set of "Feeling Faces" as well.

The emotion unit of PATHS teaches children that all feelings are OK to have. All behaviors, on the other hand, are not OK. Some behaviors are OK, while some are not. In other words, children are taught to judge behaviors, not feelings. The children are taught that feelings are signals that communicate useful information. If people learn to attend to what their feelings are telling them, the information can be beneficially utilized in making decisions about what to do next.

Familiarity with emotional labeling and with subtle connotative meanings greatly facilitates verbal mediation of affective states. This in turn helps improve self-control, cognitive understanding of emotional situations, problem-solving skills, and so forth (Furman, 1978; Katan, 1961; Lur.a, 1980). In addition to specific concepts, the children learn to recognize their own feelings and those of others, monitor their affective states, understand attributions that link causes and emotions, take multiple perspectives into account simultaneously, recognize how their behaviors affect others and vice

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versa, and so forth. The emotion lessons thus provide a developmentally-based framework for the subsequent problem-solving lessons.

The third focus is the development of skills important for interpersonal problem-solving. The skills in the preceding domains are all prerequisites for learning competent interpersonal problem-solving, so lessons on this topic do not begin until the groundwork has been covered by previous instruction. After examining numerous cognitive-behavioral curricula for hearing children (Camp, et ai., 1977; Elias, 1983; Kendall, Padawer, Zupan, & Braswell, 1985; Kirschenbaum, 1979; Shure & Spivack, 1978; Trupin, 1981; Weissberg, et al., 1980), we believed that in all of them, problem-solving was introduced without sufficient attention to emotional understanding and awareness. We strongly felt that because of inadequate attention to emotional understanding, the effects of these curricula were likely less powerful than they otherwise could have been. As Kendall & Braswell (1985) suggested, "Improving the chi'd's ability to accurately recognize and label his/her own emotional experiences, as well as the emotions of others, may be a necessary step for improved interpersonal problem-solving" (p. 135).

Following the conceptual model developed by D'Zurilla and Goldfried (1971), Shure and Spivack (1978), and Weissberg, et al., (1980), the problem-solving content area in PATHS was expanded to sequentially cover the following topics:

1. Stopping and thinking
2. Problem Identification
3. Feeling Identification
4. Deciding on a goal
5. Generating alternative solutions
6. Evaluating the possible consequences of these solutions
7. Selecting the best solution(s)
8. Planning the best solution (and/or combining different elements of various solutions to formulate a comprehensive plan)
9. Trying the formulated plan
10. Evaluating the outcome
11. Trying another solution and/or plan, or alternatively reevaluating the goal and/or problem, if an obstacle results in failure to reach the intended goal

Most other curricula that teach interpersonal problem-solving to children utilize 5 to 7 sequential steps. However, on the basis of our three years of research using The PATHS Curriculum with deaf children, we found that 11 specific steps actually need to be taught in order to adequately cover the full sequence involved in real-life problem-solving. The three critical steps that are not usually found in past models include (1) identification of feelings prior to generating solutions, (2) use of detailed planning to operationalize the best solution, and (3) self-monitoring and evaluating of the outcome of the formulated plan after it has been put into operation.

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PATHS teaches children that problems can be solved. In addition, PATHS provides children with a framework that allows them to become more effective problem-solvers. Finally, PATHS emphasizes that each individual is responsible for defining and solving his/her own problems; we can turn to other people for assistance, but no one else can solve our problems for us.

Overall, we believe that there are four major factors that we are trying to effect with PATHS by focusing on self-control, emotional understanding, and problem-solving skills using the process of creative self-expression. First, we teach children to "Stop and Think," a response that facilitates the development and use of verbal thought. Second, we provide children with enriched linguistic experiences that will help mediate an understanding of self and others. Third, we teach the children to integrate emotional understanding with cognitive and linguistic skills to analyze and solve problems. Fourth, and very critically, we encourage the development of verbally mediated self-control over behaviors.

In summary, the PATHS Curriculum provides teachers with a systematic and developmental procedure for reducing adverse factors which can negatively affect a child's adaptive behavior and ability to profit from his/her educational experiences. PATHS is designed to help children (1) develop specific strategies that promote reflective responses and mature thinking skills; (2) become more self-motivated and enthusiastic about learning; (3) obtain information necessary for social understanding and prosocial behavior; (4) learn to generate creative alternative solutions to problems; and (5) develop the capacity to anticipate and evaluate situations, behaviors, and consequences. These skills, in turn, increase the child's access to positive social interactions, thus reducing isolation, and provide opportunities for a greater variety of learning experiences.

RESEARCH FINDINGS

PATHS was experimentally implemented and evaluated using six randomly-selected treatment and five control classrooms of elementary school-aged deaf children in four different school districts in the Seattle-Tacoma area. The experimental design utilized pre, post, and follow-up testing with matched treatment and control groups; age was also analyzed as an independent variable. All of the experimental teachers and aides were supervised by project staff on a weekly basis, which we considered a very important component of the PATHS program. During the second year, the five control classes received PATHS.

Our research findings supported our predictions of curriculum effectiveness (Greenberg, et al., 1985; Kusché, 1984; Kusché, 1986). The experimental groups showed significant improvement in role-taking ability, problem-solving skills, and reading achievement. Moreover, teacher ratings of problem-focused change indicated that the curriculum was effective for a wide variety of difficulties, including poor communication skills, immaturity, aggressiveness, attitude towards authorities, poor self-concept, short attention span, feelings of isolation-rejection, and antisocial behavior. Teacher ratings also indicated significant increases in frustration tolerance.

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In addition, both the younger and older experimental groups improved significantly with regard to emotional recognition and reading of emotion labels. Somewhat surprisingly, the younger experimental children (average age - 7 1/2) were as able to recognize emotions and read their labels at posttest as the older experimental group (average age - 10 1/2). Similar improvement was not found with the control children at the end of the first year (prior to receiving the curriculum), but our findings were replicated at the end of the second year (after the control children had been given the curriculum).

In short, our findings indicated that self-control, emotion concepts, self-understanding, and interpersonal problem-solving skills could be effectively taught to deaf children, that our curriculum was very effective in facilitating these goals, and that improvement in a wide range of behavior problems could be effected by the PATHS Curriculum. Our informal observations impressed us with the level of enthusiasm and motivation the children demonstrated in their desire to communicate and learn about affective-laden topics. Utilizing emotions as content material also appeared to have a positive effect on achievement motivation. Our data and observations, as well as teacher reports, further indicated that the children profited from and enjoyed learning the cognitive-related processes embedded in the curriculum (e.g., memory encoding and hierarchical thinking strategies).

ADAPTING PATHS: PREVENTING SUBSTANCE ABUSE

In order to optimize the educational value of the PATHS Curriculum, generalization strategies are included to promote understanding by associating newly-learned information with real-life behaviors and situations that occur throughout the day. The rationale for these generalization procedures is that in order to be useful for daily living, information that is taught during classroom lessons must be as similar as possible to that which will be needed for real-life experiences.

One of the repeated criticisms of past cognitive training programs has involved the numerous reports that newly acquired cognitive skills do not generally translate into more adaptive social behavior (Sharp, 1981; Abikoff, 1985; Pellegrini & Urbain, 1985). This should not be a surprising finding. Cognitive training requires only the use of higher intellectual processes; social behavior, on the other hand, involves emotions in addition to intellect. Without adequate understanding and awareness of affect, intellectual skills alone are not likely to be sufficient for mediating emotionally-charged situations, especially when affect is strong.

It is also not helpful to "preach" to children or to try to impose values or beliefs on them. On the contrary, such practices tend to infantilize individuals and to increase dependency. Dictating a set of rules, norms, and standards to be followed frequently results in children learning to be "good at sneaking" and to be distrustful of adults. During the socialization process, each individual needs to establish his/her own set of beliefs based on reasonable criteria. When children respect and like the adults with whom they interact, they are naturally motivated to "become like them." Part of this identification process involves adopting similar beliefs and values. "One

critical activity deaf people need is the opportunity to generate dialogue with a variety of people to accommodate social information to modify their own belief systems . . . As the deaf person makes choices intentionally, s/he will do so based on the experiences with significant others around him/her" (Culhane & Porter, 1983, p. 36).

One of the major goals of PATHS is to assist each child with the development of his/her personal system of beliefs and values. As a result of numerous lessons, interactions, and dialogues, children involved with PATHS learn competent skills and improve capacities that are crucial for emotional health and for mental health processes and practices, such as:

1. Improved communication skills
2. An understanding of the importance and usefulness of talking about feelings, ideas, and beliefs
3. Improved ability to express emotions using therapeutic concepts and vocabulary
4. Increased abstract reasoning skills
5. Understanding of cause-effect relationships
6. An increased awareness of problems and the roles that the self and others play in problem generation
7. Improved perspective-taking ability
8. Increased social understanding
9. Understanding that problems can be solved and that choices can be intentionally made
10. Motivation to engage in open communication and dialogue with others
11. An improved capacity to listen to others and to share information
12. The ability to learn from mistakes and to generate alternative solutions
13. An improved capacity to plan ahead and to set realistic goals
14. The ability to project into the future
15. The ability to formulate, test, and evaluate hypotheses
16. Healthy self-esteem and self-understanding
17. Motivation to be responsible for one's own actions and feelings
18. An understanding that problems require effort, time, and active commitment for successful resolution; i.e., other people cannot "fix" your problems for you and it won't work to simply wish them away

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19. The ability to trust and work with
    helping professionals in a positive
    and rewarding way
20. The desire to develop and modify a
    personal belief system within the
    context of human relationships
21. An increased sense of self-efficacy

Once learned, the PATHS process can be applied to hypothetical situations involving possibilities in the future (e.g., the use of alcohol and drugs). We therefore believe that for older children and young adolescents, the skills listed above and the PATHS paradigm can be easily generalized for use in the prevention of Substance Use Disorders.

Information related to alcohol and drug use can be taught on a cognitive level, and it is important for children to learn this relevant knowledge. However, this information, in and of itself, is unlikely to prevent substance abuse, because substance abusers do not make rational, cognitively-based decisions to abuse drugs or alcohol. Rather, substance abuse almost always involves an emotional basis. Thus, prevention must address emotional issues to be realistically generalizable.

Once adolescents have been taught information regarding alcohol and drug abuse and have acquired the PATHS-related skills listed above, these two areas can be combined in a very effective way. In this regard, it is suggested that PATHS could be used in conjunction with one or more of the educational programs presently available to teach deaf adolescents about chemical substance use (e.g., Kapp, Clark, Jones, & Owens, 1985; Mihall, Smith, & Wilding, this volume).

As noted earlier, one of the teachers in our project, Mr. Rudy Flores, advanced this very innovative idea by utilizing the PATHS framework for lessons involving substance abuse. Mr. Flores first taught The PATHS Curriculum to his class for one year. Since he had the same group of children the next year, he reviewed the curriculum again, and at the same time also taught his class factual information regarding alcohol and drugs. He then combined the two bodies of knowledge to discuss alcohol and drug abuse with his students in a highly effective manner.

The student-teacher dialogues we observed were extremely impressive, both with regard to the content of information and to the level of communication demonstrated. The young adolescents in this class (ages 11 to 13) were highly motivated to discuss substance use. By examining this topic at this critical age (prior to actual substance use), these children were able to evaluate their feelings and to propose possible outcomes to hypothetical examples. In this way, they could learn about substance abuse both cognitively and emotionally, without having to experiment in real-life situations. We believe that this will provide a kind of "innoculation" to the realistic experiences that will confront them in the near future and that this will ultimately assist in preventing the development of Substance Use Disorders. In other words, the children were able to practice in thought and fantasy that which they will soon be facing in reality.

A LESSON ON ALCOHOL ABUSE

In one discussion on alcohol abuse, the teacher brought in a newspaper article that had been published the day before and read it to the class. The story involved a 19-year-old boy who had died of alcohol intoxication at a party after his friends had encouraged him to drink a large amount of alcohol as quickly as he could. After reading the story, the teacher pointed to the problem-solving chart in front of the class and began the following dialogue, which took place in Total Communication (T represents Teacher, S# represents a particular student):

T: What is the one thing that always, always gets us in trouble?

S5: Friends.

T: Well, sometimes friends get you in trouble. Yeah.

S4: Listening to other friends and drinking alcohol.

T: Listening to friends and drinking alcohol. Maybe. OK, but let's look at the problem-solving page up here. What do you think is the one thing that made all of this trouble happen? What is Number 1?

S2: Stop and think.

T: Do you think that the young man - Kelly - did he stop and think?

S5: No.

S3: How old was boy?

T: He was 19. Nineteen years old. He was still a teenager, right?

S4: But not yet 21?

T: No, he was not yet 21. Not old enough yet to legally - legally drink. What was the problem? Number 2? What was the problem? Can you tell me the problem?

S4: His friends encouraged him to drink a lot of alcohol.

T: His friends encouraged him to drink a lot of alcohol? OK. Can you think of another problem?

S2: And he tried to see how fast he can drink and see what would happen if he get very drunk. He thinks it's funny.

T: OK, he tried to see how fast he could drink. OK What do we know about alcohol and the amount you drink and how fast you drink? What happens to the body? Do you remember? It's been a long time since we discussed that. Do you remember? What happens - what happens to the body when you drink too much and too fast? Do you remember?

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S6:   I think that he lose his control.

T: He will lose control? Over what?

S6:   I don't know. Alcohol, I think. But he won't remember. Throw up.

T: He won't remember things? What else?

S1:   And use - will hurt her body and will get throw up.

T: OK. It can hurt his body and make him throw up. What else?

S4:   You said three things. First you drink, feel sick, then second is u-n-c
      [unconscious], then death, then third is death, you said.

T: First you feel sick, unconscious, and then the third thing is death. OK.
      But one of the things that we learned was that if you are going to drink,
      you can have one ounce of alcohol in one hour and still not really hurt
      your body. How much did the boy drink? How many ounces is in one quart
      of whiskey?

S3:   Forty-five. Forty-five.

S5:   Five dollars.

S2:   I think this much, this high.

S6:   No, no, eight, eight.

S4:   It was thirty - wait - thirty-two. Thirty-two.

T: Is it thirty-two? Thirty-two?

S4:   Thirty-two ounces.

T: OK, I think with alcohol it is thirty-two ounces. It's not a full quart.
      I think it's thirty-two, isn't it? I'm not sure. It's a little bit
      less. Now, what would happen to a body if you drank fast, thirty-two
      ounces of alcohol?

S5:   Can't clean.

S2:   Can't breathe.

T: He stopped breathing, right?

S6:   Liver can't clean it all.

T: Right, your liver can't clean up all the alcohol fast enough, and then
      what happens? It goes into - it goes into your system, OK, because your
      body's not cleaning up the alcohol, and then what?

S4: Then stuck in liver [points to his stomach].

T: Well, it's not getting stuck, but it's just really, really messing up all of your organs.

S4: And then through, spread through body.

S5: [Points to stomach] Liver.

S2: And to stomach too.

T: Alcohol – do you remember that alcohol does not stay in your stomach? It's the one thing that you drink that goes through the tissue, through the lining, right? And it makes you drunk, because it does not stay here and go through into the liver. Some, yes, but not all. Now [pointing to problem-solving chart] if you were a person who was sitting watching this boy drink, what is your problem?

S1: Friend will get trouble.

T: Your friend will get in trouble? Maybe.

S5: See him there.

S4: I know about it.

T: Yea'. Do you have a problem if you're watching someone drink too much alcohol and you know what it can do to his body? Now he is 19 and he didn't know what can happen. Now if you are his friend and you're standing there and you're watching, what is your problem? What is your responsibility as a friend? To let him go?

S5: You say, "No!" Say, "Stop!"

T: To stop him? To do what?

S2: Tell him to ignore it. Tell him to ignore the other people. They are trying to make you drunk.

T: To tell him to ignore the other people? They're trying to make you drunk? Or what else?

S4: Or kill him.

T: Or kill him? Yeah. What else could you say to him?

S5: That can kill you.

T: That can kill you? OK.

S2: He can throw up with lots of blood.

T: Yes, huh-huh. He threw up blood? That's right.

T: OK, now, how do you think the boy felt? [Number 3] Why - why do you think the boy wanted to drink that alcohol? Why did Kelly want to drink the alcohol?

S6:   To be show-off. "I will be best one - drink."

S2:   He want to show people that he think he can drink fast and all the alcohol.

T: Is that important to young people do you think? To see who can be the best drinker? It must be, or he would not have done it.

S6:   "The World - The World's Fastest Drinker," he think.

T: To see who's the fastest drinker? The fastest drinker?

S1:   Use - drink some. Use - just thinking, "I know, I understand." [role-plays acting cool]. "I understand, know."

T: They think that they're cool or smarter, maybe?

S1:   "I know, I understand, I know."

S3:   Do a world record. Do a world record.

T: Do a world record? I don't know. Now - now, I think that I agree with S6. I think that the boy was being a show-off, but the question is, why do people need to be show-offs? Why do you think people need to act and do things that they know can hurt them? Why?

S6:   They want to feel the same [like others]. Want to get them attention to them. And maybe have more friends. Like [similar to] a famous person that signs autographs.

T: Maybe he thinks that will make him more friends? And maybe become - his friends will think he's famous a little bit? Maybe.

S4:   Maybe he was not really trying to show off, but he was afraid, because he think his friends will get - and if he think they will beat him up if he doesn t drink.

T: You think maybe they would beat him up? 19? Maybe. Maybe, I don't know.

S2:   Maybe he thinks that he will lose friends.

T: Excuse me? Again?

S2:   OK. Maybe he thinks that if he won't drink, he will lose friends.

T: Maybe he thinks he'll lose friends?

S2: Maybe.

T: OK.

S4: Why boys say, "Go, go, go, drink more!"? What for?

T: They're encouraging him. They're pushing him to do that. Not one person
     told him to slow down or stop. Not one. All of them were saying, "Go,
     go, hurry, hurry, drink, drink, drink, go, go, go."

S5: They think that fun.

T: Maybe they think it's fun to what? Watch?

S5: No, just — I don't know.

T: Well, maybe they think it's fun. Maybe you're right.

S4: Maybe fun — maybe they watch, see what will happen, look, "Whoa." See
     drink that.

T: Yeah. Maybe they think it will be fun to see what happens. "Let's watch
     and see how he acts. Maybe he'll act silly." Did he act silly? Did he?

S5: He was stupid.

S2: He wants to go away to — or is ashamed to know.

T: Now, I have another question. How do you think his friends felt after he
     died?

S5: Surprised.

S2: Feel sad.

S6: Mad.

S5: Scared.

S1: Afraid.

T: Afraid?

S4: A little b,t.

S3: Maybe it s-c-u-i-c [suicide].

T: I don't think it was a suicide. No, he was trying to show off in front
     of his friends.

S3: Oh.

T: He did not try to kill himself.

S4: Maybe if scared of everything, then they won't want to drink anymore.

T: Maybe they won't want to drink anymore? Maybe they are afraid? Maybe.

S4: Or go to jail.

T: Maybe they'd go to jail? I don't know.

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T: Let's finish here. Let's continue talking about feelings. How do you think the mother and the father felt after their son died?

S5: Mad.

T: Mad? How else? How else did they feel?

S6: Disappointed and s d - then never see him again.

T: Very, very disappointed and sad, because they'll never see him again?

S5: Maybe boy copy his parents drink.

T: Maybe his parents drink. Maybe he copied them.

S4: Mad. Maybe mad at his friends for saying, "Go!"

T: Maybe the parents are mad at his friends. Maybe. OK. Maybe.

S2: Or maybe he has girlfriend - guess.

T: Maybe he was what?

S2: Girlfriend - guess.

T: OK, well how do you think she felt?

S2: Very sad.

S5: Disappointed.

S3: Mad.

T: OK, mad, sad, disappointed.

S4: And scared, because they will get friends to judge and court.

T: I do not think that they will do anyth ng to the friends. Because whose choice was it to sit down and drink all of that alcohol?

S5: Kelly.

T: It was Kelly's choice.

S1: To take them – the parents will take the friends to jail.

T: They can't do that.

S1: Why?

T: They did not force Kelly to drink. It was Kelly's choice. You have the same choices and that's what we've talked about all year. You will have the same kind – the same kind of choices to make when you go to [name of junior high school] and [name of high school]. The same kind. I had them to make myself. Now, I see young people your age, and they put on their bandanas and they tie them around their legs, and then I see them put on cool hats, and they come to school, and then I see them with – with their glasses – their Michael Jackson glasses. OK. Why – why do you think we do things like that? Why? Why do we do that? I did the same thing and you do the same thing. Why?

S4: Maybe they want to show off.

T: Maybe they want to show off? I don't know. Why?

S4: Or maybe be better.

T: You think maybe it will make them better than the other kids?

S6: Someone told me that. I said, "Why you become a show-off?" They said, "for they want to get other people – children – get their attention." They said that.

T: They want their attention? I told you before that they – that they show off because they want their attention?

S6: They told me why tie bandanas on legs.

S1: Sometimes people put on show off, cool hats, then go to park, and people see them, think cool, and give them beer, sometimes.

T: Maybe. OK.

S4: Maybe they want to act grown up. They are OK, tough.

T: OK. We want to act grown up. I think a lot of times on TV, movies, magazines, we see other people that we think are cool - how they dress,

what kind of clothes and shoes they wear, and we think that they are
pretty neat. So we try to copy them. And the same thing happens to
adults. The same thing happens in college. The same thing happens in
junior and senior high school. Everyone wants to feel accepted. You
want to feel like you're part of the group. You want to feel like you're
not alone. It's really important to feel like you have friends who say,
"Hey, I think you're OK." But one thing you have to remember is that
there's always, always a line over here that you're going to have to make
for yourself and say, "This is the line. I'm not going to go over that
line for my friends." You have to decide what that is for you . . .
Choices, choices, choices. Scary choices that you have to make, right?
And I had to make the same ones, too.

S4: I think to say, "No!", is a little bit scary.

T: Yes, it's scary. A lot of the choices that we have to make are scary. A
lot of choices and we talked about them too - alcohol, drugs, sex - all
of those things, we're going to have to decide on ourselves.

The second half of this lesson continued with a discussion of Kelly's
possible goals and those of his friends, the different solutions that various
individuals could have tried to avoid the problem, and the possible conse-
quences of different types of behaviors that might have been chosen (as well
as of those that were selected by Kelly and his friends). Finally, the class
discussed and reached a concensus as to what the best solution for avoiding
the problem might have been.

It should be emphasized that these profoundly deaf adolescents (ages
11-13) were not a specially selected group nor were they particularly gifted
with regard to intelligence or language skills. Their speech for the most
part was nonintelligible and they evidenced many flaws in their grammar.
However, these deaf students demonstrated that they knew how to communicate,
to ask intelligent questions, and to think for themselves. It can also be
noted that their teacher never stopped them to correct their grammar, but did
frequently repeat back their statements to them using proper English grammar.
The teacher also clarified the content of their communications when he did not
understand what it was they had said. These are the same types of inter-
changes that caretakers demonstrate with young children who are learning to
talk, and these seem to be the types of interactions that facilitate the
development of natural communication and social dialogue.

A LESSON ON DRUG ABUSE

In the next lesson, the student numbers refer to the same children as in
the previous lesson. However, there is now a new student (S7), who had joined
the class several months before   This student had previously received
instruction in "oral only," self-contained classrooms for deaf children, and
this was his first TC class. Although he had only been exposed to sign
language for a short time, he had picked it up very rapidly, and he was almost
fluent in it at the time this lesson was filmed. You may notice, however,
that his understanding of the concepts is not always as sophisticated as that
of his peers, which is understandable, since he had had much less exposure to

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PATHS and material related to substance abuse. An interesting aside is also provided near the end of this lesscn, when two of the students spontaneously discuss their conceptualizations of mental health facilities (a topic in which they had not received any instruction).

This lesson began with the teacher (T), the student teacher (M), and the aide (A) role-playing the following skit:

T: We are all 15 and 16 years old and we're driving to the movie with M and A and the situation begins with me offering my friends something I have called "reds."

T: "Look what I have! Some pills! Want one?"

M: [M, while driving the car, takes the bottle, removes a pill and swallows it.] "Thanks."

T: "You're welcome." [T turns to A, who is in the back seat of the car.] "Want one?"

A: Shakes her head no.

T: "What's wrong?"

A: "I don't think I should take these."

T: "Why not? Are you afraid?"

A: "No."

T: "I think she's chicken."

M: "What a baby! What a baby!"

T: "Mother's girl! It's not going to hurt you. Just one pill is not going to hurt anything. Go on try it, it's fun."

M: "What a sissy!"

A: "Are you sure?"

T: "Sure. There's nothing wrong with that."

P: "It won't make me sick?"

T: "Nah. It's not going to make you sick. Go on, try one."

M: "Come on. Don't be a baby."

P: "Well, maybe just one." [A opens the bottle and swallows a pill.]

-------------End of role play. Class discussion now follows.-------------

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T: We saw the situation that A, M, and I just finished playing – role-playing. I want you to think about A's problem. Many, many times we will be influenced by our friends, and I want you to think about A's problem. She had a real serious problem. OK. Let's look up here at our problem-solving page. Number 1.

S7: Stop and Think.

T: Did anyone stop and think?

S4: A little bit.

T: Who stopped and thought a little bit?

All: A.

S4: But the driver didn't think.

T: But the driver didn't think? Did I think?

S3: No.

T: Who was the bad influence?

S7: You and M. You and M.

T: Both of us, I think. I had the pills, but who took them? Both of us, right?

S7: Number 2. Identify the problem.

T: What is A's problem? Can we identify that?

S6: Because A don't like that pill. She not like – they dangerous for her.

T: They were reds. Do you remember what a "red" is?

S4: Poison.

T: Well, it's not poison. It can be if you take a lot.

S2: It's medicine.

T: It's a medicine that the doctors give you. It's a pill. What kind of pill? A red. Do you remember from our drug and alcohol unit?

S4: A sleeping pill.

S7: Make a red face – a red face.

T: They're colored red, and the doctors give them to people to make them go to sleep easier, and they can be very, very dangerous.

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S2: If the driver falls asleep . . .

T: And what did we learn about taking drugs and alcohol and mixing them?

S5: You can die. You can die.

S1: It's not good. You could die.

S2: You could throw up.

T: So, what again is A's problem?

S4: She don't want to take the pill from her friend. Maybe she knows about it, maybe.

S7: She - A did not like to touch the medicine - can hurt her body.

T: If she takes it and swallows it, it can, right?

S6: And who is driving car can get accident. That could be very, very dangerous for them.

T: [Number 3. Identify the feelings.] How do you think that I felt when I came out with the pills? How do you think I felt?

S4: Maybe proud, because, "I am the one who have it."

T: How else do you think I felt?

S1: Having a good time.

S6: Think it won't hurt you.

S7: I think excited. "Ha, ha, ha. I like it." [Models taking and offering the pills.] Act like a baby.

T: You think that maybe I acted like a baby?

S7: Nods. "Ha, ha, ha." [Models the role again.]

T: Do you think that maybe I showed off a little bit?

S3: Yes.

T: How do you think M felt as I gave her the bottle of pills?

S3: She feel happy and see, will eat them.

S2: Fine. [Pantomimes taking the bottle, eating a pill, returning the bottle.]

S7: I think M is - (pause) - feels like - (pause) - I don't remember how to say - feel comfortable?

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T: She feels comfortable. She did not look afraid, did she?

S6: I think she will act like that because she don't want T to make chicken of her. Her fine and take it, I think. He the boss, say, "Take it." Feel bad, say, "Take it." Like that.

T: So she was influenced by me and maybe afraid of what I would say?

S6: Yes.

T: Ahhh. OK.

S7: And if you give M the medicine, and M won't be - will not be a chicken, she takes - just - don't be - just fine. [Acts out taking the pill and returning the bottle.] OK, OK, I eat, OK.

T: Do you think what she did was a good idea or a bad idea?

All: Bad idea.

T: Now how do you think that A felt? She was the third person, and she was not very comfortable.

S1: She feel disappointed and sad. She did not want to take that medicine.

S2: She was afraid to not join the whole group. Afraid.

S4: And she will be scared and worried if she gets trouble.

S7: And some police will come and check in.

S1: And she worry - she want to avoid them, because she not want them to give more medicine to her. Maybe she want to avoid them.

S6: Gang. Gang. Act like a gang. One - both. Want drugs, cheat, like that.

S4: Maybe A knows what will happen to everyone if they take it. Get sleepy, have accident.

T: OK, now I was the bad influence. What do you feel my goal was? [Number 4. Decide on a goal.] What did I want to see the group do?

S4: You wanted to see your friends get it, to accept and copy you.

S1: And 'e a show-off - pass out pills - a show-off.

S7: And if you and M and A go to college, and some police officer would smell anything, get - and you will get kicked out of college.

T: What do you think that M's goal was? She was driving the car. Did she have a big responsibility?

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All: Yes.

T: What was her responsibility?

S6:   Driving the car. She will hurt herself if she took it.

T: And who else could she hurt?

S5:   She can hurt her friends.

S2:   And she will hurt other people in other cars.

S1:   When they take medicine, will get sleep, will get accident, swerve all over, get hit.

T: That's right.

S1:   And go to the hospital.

T: So, what do you think that M's goal was?

S7:   She said that, "Don't eat that pill."

T: She did. She ate it. Do you think that maybe her goal was to be a part of the group? She wanted really, really badly to be accepted. What was A's goal?

S4:   Not to eat it.

T: Do you think she thought about that before she took it?

S4:   I think A thought a little bit, and knew, but then later she saw her friend teasing her and she took it.

T: Is that a good reason to take a pill?

S3:   No.

T: Sometimes we forget and sometimes do things we know are wrong because of our friends' influence.

S7:   I think if you and – if some friends do not like you, and then you give some medicine. Some people do that.

S3:   Some people think that pills do not hurt people.

T: And what do we know about pills?

S2:   Dangerous.

S4:   Can fall asleep fast, even at daytime, or when you are swimming and drown.

T: Do you remember what the most important information that we found out about pills was that always, always, always look where?

S5: On the back.

T: On the bottle.

S5: Nods.

T: And then what?

S5: Read it. And some (pause) prescriptions say, "Don't eat it to pregnant.", or something like that.

S6: Or driver.

T: Or if you're drinking?

S4: Or you can drown if sleep and a little bit water and swallow.

T: Sure, you can drown.

S7: And if - (pause) - I don't remember.

T: Have you seen a bottle of pills that says, "Share these with your friends?"

S5: No.

S4: Never.

S7: I never heard of that.

T: I've never seen that.

S4: But maybe someone can change it - rip it - write, type or it on, maybe.

T: I've never seen that.

S4: I know.

T: Why do you think I shared them with my friends? Not a good idea. Now let's look up here. Stop and think of solutions. [Number 5.] What could we have done, anything?

S5: Stop and think before you take the pill.

T: That's one thing. What could M have done? Anything?

S7: She can make sleep, can't wake up, she make car crash.

S2: She should have said, "No thank you."

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S4: Or if say, "No." If say, "Can hit, crash."

S6: Ignore him. Drive.

S1: She think she not want car – medicine [medicine in her car], then, "Go away," or say, "No thank-you." (Pause) Or, ask him, "Get out of car!" – say, not want him in.

T: That would have been a very, very strong thing to do, but I think that would have helped solve the problem. That is a good idea. I like that idea.

S4: If can't do that, say, move away from the others, but think more of others than her.

T: Maybe. That is one thing to think about right? Who is responsible for the lives of the people in the car?

S5: Driver.

S2: She should have said, "I don't allow people take drugs in my car."

T: Maybe. Maybe that's a solution.

S7: Or, if A did – if A say, "No thank you, I'm going to walk away." – or say, "Get out!"

T: Do you think A could have done anything differently?

S5: Say, "No thanks."

S4: She say that, I think. She say a little bit that.

T: She tried. She was thinking about it, I think.

S1: Or sometimes when they use pills, sometimes they think she want to get out of car, not want them give her medicine, say, "Go home!", walk away.

T: I think the important thing is to notice that most of the time we do not want to be alone, out of the group, or wrong. Most of the time, we follow the group, because we're afraid of what they will think. And it's not blaming M, blaming A, or blaming myself, but that seems to be the way groups work. And it's not only teenagers. Adults do the same thing. Now, let's think about the group and then individually, what do you think happened, or could have happened to the group – the three people – next? [Number 6. Evaluate the consequences.]

S4: Killed.

T: What else?

S2: I don't know.

S4: Maybe A sleepy, and M became sleepy, stop the car in time – only sleepy – then the police will come, see sleepy. If guess, then will take to jail.

S1: Sometimes when they use pills, you get lady to call police. Ask her, she don't want them to give pills. She call police, get them out. Call police, can get them out.

S7: If you – If they was sleepy and you dropped a pill out of can and police come, check, "What is they doing?", thinking, and check all of the car, and if saw the can of pills and read it, "It can make sleepy – them sleepy."

T: Let me give you an example. Let's pretend that we kept going and M was driving the car. And then let's say that maybe M became a little bit sleepy, not a lot, and maybe she started driving a little bit funny [models this], and maybe a policeman saw her. And then let's say that maybe they stopped the car, and then they saw that her eyes looked funny, because many, many times your eyes change when you're taking pills like this. Maybe they checked us. Then what would happen to me?

S7: Take you to jail or take you to the hospital.

S3: Jail, maybe.

S6: Get a ticket.

S1: My mom just got a ticket, I know.

S7: [Models being in a straitjacket.]

S2: Take to hospital first, then if you are fine, go to jail.

S4: Or to court.

S7: Or when you feel fine in the hospital, then not go to jail, just going in sadding, like white jacket [models being in a straitjacket again], for funny thing.

T: I don't know. I don't think so.

S2: Sometimes retarded in hopsital for strange people only [models being in a straitjacket], like that.

T: Of the things that we have discussed, which solution to the problem do you think would have been best for everyone? [Number 7. Select the Best Solution.] Not just for me, the bad influence, and not just for M, the driver, or not just for A, the person who was forced to take the pill. What would have been the best solution to the problem?

S4: For them to tell the man to get out of the car for influence them bad things.

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T: OK, that's one thing. Can you think of maybe another soluion? (Pause)
     It's hard. It's very, very hard.

S4: If they said, "Out!", think - mad, fighting.

T: Maybe there'll be a fight? OK. Other problems?

S1: Sometimes then A discuss to medicine, then to not take pills or medicine
     - discuss her not want take pill in the car.

T: But do you remember that her friends were teasing and teasing her and
     calling her a baby, a mother's girl, chicken, "What's wrong, you
     afraid?", and like that? And then she began to feel a little bit
     embarrassed and maybe very nervous, but she took the pill anyway. Do you
     remember when we discussed about the boy - the young man - who drank all
     that alcohol? What was the one thing that never happened? Why did he
     die?

S4: From listening to his friends.

T: But what were - did anyone tell him to stop?

S5: No.

S4: Nobody.

T: Did anyone in this situation tell me to stop?

S6: No.

T: Why?

S4: They want to be part of the group.

S1: Sometimes they think he can stop and think, sometimes. A little bit.

T: Sometimes I think that people feel bad things always happen to other
     people. I'm not going to get hurt. We're not going to have an accident.
     He will not die. We can take the pills and nothing will happen. And I
     don't know why we feel that way, but many, many times, adults and young
     people feel the same, as if nothing can happen to me, but then you read
     over and over again that people do get hurt. I hope - I hope that if you
     have a situation that is similar, that maybe you can use your under-
     standing of alcohol and of drugs and use your good sense and try to be
     the strong person in a group, because maybe what you do can influence
     your friends.

SUMMARY AND CONCLUSIONS

    Culhane and Porter (1983) noted that, "Establishing the kind of meaningful
communication between a deaf child and the surrounding world which fosters a
developing sense of intentionality is a difficult, and perhaps relatively

Infrequent, accomplishment" (p. 35). We believe that this is both unfortunate and unnecessary. Deaf children can learn to be critical thinkers when they are provided with the prerequisite tools and when they are given permission to develop their own values and intentions within a nonjudgmental environment.

As Culhane and Porter further suggested, "If intentionality relates to the why and purpose of behavior, values relate the the should and direction of behavior. Values represent the standards by which choices are made and intentional behavior is guided" (p. 36). In order to make meaningful choices in life, individuals must have the freedom to explore their values and develop their own belief systems. Good communication, emotional understanding, social awareness, and uncritical acceptance facilitate this type of personal growth.

Substance Use Disorders do not result from meaningful life choices. Clients do not come into our offices and say, "Well, Doctor, you see I was suffering from a clinical depression and chose to medicate myself with alcohol rather than undertake psychotherapy and use antidepressant medication." However, all individuals, hearing and deaf, try to make sense out of their behaviors, which frequently involves erroneous causal attributions about the present (e.g., "I don't like my work;" "My wife nags me."; etc.). According to Steitler (1985), the two most frequent justifications given by abusers for their need to use alcohol and/or drugs are anxiety and boredom. In general, most substance users have little or no awareness of the dynamics that underlie the emotional pain they are trying to eliminate or mask.

Through the use of the PATHS paradigm, deaf children and adolescents can explore the causes of behavior, reasons for feelings, and can hypothetically explore various solutions to problems. Any of a number of value-laden topics can be adapted to the curriculum, such as smoking, sexual abuse, sexual behaviors, death, suicide, prejudice, handicaps, and so forth. An additional area for creative adaptation would involve education in the area of mental health (e.g., When and why should an individual seek treatment?; What does one do in therapy?; Do only "crazy" people go to therapy?; Do therapists "tell" on you?; Where do deaf people go when they need to see a therapist?; How and when does a deaf person use an interpreter in therapy?; etc.).

It is very important, however, for the teacher or counselor to be prepared for the types of thoughts and feelings (and even consequences) that are likely to arise. Many teachers (and even some therapists!) are not comfortable discussing feelings and attitudes, but find that they become much more relaxed as the curriculum progresses. We also believe that supervision is extremely important, at least during the first year of using the curriculum, since this is an unfamiliar area for most individuals. (One school counselor, for example, told the first author that when she began a group to teach deaf female adolescents about sex abuse, 8 of the 14 teenagers in that high school class eventually reported past instances of sexual abuse from family members! She was then additionally appalled to find that there were no services in the area available for deaf adolescents).

Access to an adequate vocabulary for the subject at hand is also very important. In the area of substance abuse, at least one book is obtainable (Woodward, 1980), while Cassell and Darmsted (1983) have invented additional

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signs to fit specific drug and alcohol-related words. In the area of sexuality, at least two specialized sign books are available (Doughten, Minkin, & Rosen, 1978; Woodward, 1979).

Finally, it is obvious that the use of a curriculum will not prevent all future difficulties; on the contrary, painful feelings and disturbing problems are part of living. PATHS tells children that all feelings are OK to have, but all behaviors are not (i.e., what we do about our feelings may or may not be OK). PATHS does not make painful feelings disappear, but rather teaches children that both painful and pleasurable feelings are signals that provide useful information. If we pay attention to these signals (i.e., if we "listen" to them), we can use this information to improve and have more control over our lives. Furthermore, we can apply the knowledge that problems can be solved and utilize our problem-solving abilities to facilitate our goals.

It should be emphasized that PATHS is an educational curriculum and is not a replacement for therapy. Nevertheless, the skills and information learned during the PATHS lessons will help prepare children for therapeutic treatment if it is needed in conjunction with education or is necessary at some time in the future.

In summary, Substance Use Disorders exemplify one of the many types of problems typical in life. There are solutions, but no easy answers. We believe that adapting and generalizing the PATHS Curriculum is a good choice to select for the goal of preventing substance abuse in deaf adolescents. Using our own paradigm, we have (1) stopped to think about the issue, (2) identified the problem, (3) identified the feelings that accompany it, (4) decided on a goal, (5) generated and discussed alternative solutions, (6) evaluated some of the possible consequences of these solutions, and (7) selected what we think is at least one of the best solutions. If you are interested in pursuing this further, we will leave it to you to (8) plan the best solution, (9) try the formulated plan, (10) evaluate the outcome, and (11) if the goal is not reached, try another plan or solution.

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IN-SERVICE TRAINING FOR DORMITORY
CHILD CARE WORKERS IN RESIDENTIAL
SCHOOLS FOR THE DEAF

WILLIAM WOODRICK
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During the past two summers, 1984 and 1985, The University of Tennessee, Knoxville, had conducted a child care workshop to provide training for paraprofessional personnel employed by residential schools for the deaf as dormitory child care workers. Although the target geographical areas include the states in Federal Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) trainees from other states have also participated. The training is offered for six weeks. Successful completion of the twelve quarter hour academic credit program meets the formal training requirement for certification according to the criteria of the Conference of Educational Administrators of American Schools for the Deaf.

The child care workshops have been supported by the Unite ' States Department of Education, Office of Special Education and Rehabilitative Seervices (OSERS) Personnel Preparation Division.

According to the April 1985 Directory of the American Annals of the Deaf, a total of 3,832 hearing-impaired children attend residential schools for the deaf in the eight southeastern regional states; of these, 3,041 are residential students. During the 1982-83 school year, 487 persons were employed as child care workers by these institutions. These residential supervisors assume primary responsibility for child care, incidental learning situations, behavior management, and essentially become surrogate parents between 3:00

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p.m. and 8:00 a.m. on weekdays. They also have similar responsibility most weekends of the school year because even though children are encouraged to go home for weekends, travel distance and expenses limit many children to infrequent home visits.

During the nine-month school year the child care workers in residential schools for the deaf become the primary adult authority figures in contact with the children because they often supervise children more hours than do either the classroom teacher or the parent. Consequently, these child care workers can exert extremely significant influences on the development of deaf children between the ages of 5 and the late teens.

The child care workers are usually employed on a 40-hour week and generally work during evening or split shift schedules including weekends. The starting pay is generally near the minimum wage. Some fringe benefits include meals and lodging. Since the eight southeastern schools for the deaf are operated by the state government, dormitory personnel are usually hired from a list of applicants for "state" positions which require, as a minimum, a high school diploma or the equivalent. Because the positions offer substantial job security without requiring technical or specific skill training, the number of applicants is usually adequate. Nevertheless, the job turnover and lack of pre-service training results in employment of persons who lack training in the area of child care and who often do not have the special skills in sign language needed for communicating with most deaf children. The schools sometimes offer a pre-service training consisting of one or two-day workshops which deal with school routines, emergency procedures, etc. Most schools offer some sign language training on the job, but the training is generally only a few hours a week thereby requiring several months for most people to acquire even rudimentary vocabulary. Thus, these critical paraprofessional personnel who have enormous potential for enhancing and enriching the deaf child's educational environment, are frequently prepared only for child custodial duties. The Confernece of Educational Administrators of American Schools for the Deaf (CEASD) has set minimum standards for certification of houseparents. The certification includes successful completion of three academic courses which include the areas of child development, recreational activities, and sign communication. The certifying body specifically states that schools may not set up individual certifying programs but must utilize programs which are attached to a college or university academic program. Although the certification courses imply that the three areas should be related to deaf children, there are no training programs in the entire region which supply specific training for child care workers in the area of deafness. Although several administrators of schools for the deaf have designed some in-service training activities, none meet the CEASD certification requirements. Several schools which happen to be located near colleges and universities have encouraged personnel to take advantage of courses offered by these institutions. The local institutions of higher learning frequently do not have the staff and expertise to teach courses as they pertain to deaf children. For example, most of the institutions do not offer sign language.

During 1982, Dr. Ed Shroyer of The University of North Carolina at Chapel Hill, conducted a survey of child care workers in schools for the deaf

throughout the United States. One conclusion of the study was that despite extremely low pay, child care workers seem to receive personal satisfaction from their employment and remain in their positions for a relatively long period of time. The respondents to the study indicated a strong desire for training in order to improve their level of effectiveness with the children.

Also during 1981-82, Dr. Rachel Miller, a southeastern representative of the Kellogg Foundation Schools of the Future program at Gallaudet College, surveyed dormitory personnel in residential schools for the deaf. Training priorities of these child care workers included: child and adolescent development, time management, preventative discipline, values clarification, self-awareness and independence training, skills in decision making, and communication ability with parents, teachers, and supervisory personnel. The administrative supervisors of child care workers saw training needs in the area of child and adolescent development, sign communication, and a need for improvement in the quality of dormitory life. Dr. Miller, a consultant to the educational programs throughout the southeast region, reported that administrators frequently express a major need for staff development among the dormitory personnel.

Many local education agencies among the southeastern states utilize the state schools for the deaf as a means for serving deaf children, particularly those from rural areas. Although the enrollment of state reioential schools has dropped as more capable students are being served in local education agencies, the increased number of multi-handicapped deaf children in residential schools further complicates the role of child care workers.

During the 1982-83 school year among the eight states in Federal Region IV there were 2,931 residential deaf students. More than 480 people were employed as child care workers. It is estimated that between 70 and 80 new persons are needed each year. A survey of residential educational programs among the eight states in the region was made during the winter of 1983. The results of the survey are included in Table 1.

In summary, child care workers with minimal training are and will continue to be employed by residential schools for the deaf. The workers have completed high school or its equivalent with no training in child care nor any prerequisite competence in communication with deaf children. Rather than merely providing custodial care, these paraprofessional personnel have a high potential for enrichment of the educational and emotional environment for deaf children. Although minimum national certification standards have been specified, there is no training program in any of the eight southeastern states to prepare people to meet these standards. Even though these personnel are relatively low paid, they appear to be dedicated to their responsibilites and anxious to improve their effectiveness with deaf children.

ADMINISTRATION OF THE WORKSHOP

In May, 1983 OSERS notified the University of Tennessee of funding for the program which would include $1,000 traineeships for up to nineteen (19) trainees. The traineeship pays travel, living expenses, and tuition of workshop participants. Recruitment of workshop participants was initiated through

TABLE 1

Result of the Survey of 10 Residential Schools in Eight Southeastern States (Summer 1985)

		Totals
Residential Staff Positions		581
Positions filled by August 1, 1985		555
CEASD Certified		50
Female		375
Handicapped		111
Hearing-Impaired		106
Other		5
Racial/Minority		147
Positions Vacant		27
New Employees 1984-85		86
New Employees Needed	1985-86	45
	1986-87	53
	1987-88	64
	1988-89	55
Minimum Salary (Annual)		$ 8,460
Maximum Salary (Annual)		$13,810
Training for Certification		None
Available Trained Personal		None
Estimated Number of Trainees	Summer 1986	37
	Summer 1987	38
	Summer 1988	50
	Summer 1989	41
Total Number of Students		3,233
Total Number of Residents		2,739

residential school administrators during Fall 1983 and yearly thereafter. An effort has been made to select trainees representing each of the target states who have: a year or less experience as houseparents; potential for continuing to function as a houseparent; and evidence of motivation to increase their educational experience. A recommendation was requested from the residential school administration verifying the person's employment and expected continued employment in the dormitory the school year following the summer workshop. The trainees were selected and notified of their acceptance during the Spring of 1984. The first child care workshop was held during the Summer of 1984. Eighteen (18) participants completed the program in 1984 and sixteen (16) completed during 1985.

THE CHILD CARE WORKSHOP

The workshop has three major components: sign language training, personal development and developmental laboratory, and child and adolescent study, which are described in the following section.

Sign Language Training Component

All trainees entering the Child care Training Workshop are required to participate in a sign language course and sign language lab focusing on the development of American Sign Language skills. The students meet daily for one hour to learn communication techniques in American Sign Language in a course taught without the use of speech. The recent proliferation of research in American Sign Language has validated the existence of linguistic parameters (Klima & Bellugi, 1979; Friedman, 1977).

The purpose of this sign language class is not to narrow the philosophical approach of child care worker; rather, it is to expand the existing skills of these service providers. In an effort to do so, it is believed that expanding each worker's ASL communication skills enhance more effective communication with deaf students. The staff of this training program recognizes the emphasis many residential schools place on Manual Codes for English. It is our experience that these training programs have provided ample opportunities for child care workers to learn the system at their school. However, it is well documented that the language of the majority of deaf people is American Sign Language (Klima & Bellugi, 1979; Friedman, 1977), and hearing people who work with this population can function more successfully having acquired these signing skills.

Because the trainees enter this workshop from various backgrounds and experiences with deaf people, they represent a potpourri of sign language systems and skills. Consequently, the initial major task is to determine a common ground from which to train these persons in ASL. An initial assessment of current sign language skills is conducted by a deaf person who has had formal training in teaching American Sign Language. The ensuing course curriculum is then developed to meet the needs of the current training group.

It is important that all the trainees become as immersed as possible in using sign language while attending this training session. Use of sign language as the teaching medium, videotapes, a sign language lab with a deaf

Instructor, and interactions with a deaf person outside of class collectively encourage their skill development. Vocabulary development, linguistic principles, and deaf culture are the three areas which form the core of the course curriculm. The areas were selected because they are the most practical areas on which to focus and provide the trainees with much information and hands-on experience within the limited time frame.

Perhaps the greatest value such a course can provide is in the respect these workers develop for the language capabilities of young deaf people. This in itself serves as motivation to communicate with a child on his/her level as opposed to communicating as s/he "should be." Respect for the child and the language s/he uses is the focal point of accepting ASL as a viable language. Once this motivation is implanted, the child care worker can return to work with a greater understanding not only about communicating with their children but also their culture.

As a result of this perspective on sign language teaching, the learning of vocabulary and various grammatical structures of ASL become only pieces in the puzzle of communicating with deaf children. It was intended as well that the attitude of effective communication be built upon respect for children and acceptance of their methods of communication, whether that consist of American Sign Language or a Manual Code for English.

Personal Development and Developmental Laboratory

The catalog description for the course says that Personal Development is "a study of the relationships among self, others, and environment in contemporary culture. Topics include self-awareness, interpersonal skills, environmental awareness, values clarification and socialization." For this workshop the objectives were more specific and included the ability to play and lead five types of group communication activities and games intended to enchance the deaf student's educational and residential environment. The five types of activities are detailed later in this paper.

The goal of the Developmental Laboratory was to give practice in leading the five types of activities (the learning by doing approach). Demonstrations and practice was also conducted in order to help the participants learn and review rules and coaching techniques for basic sports (softball, basketball, soccer, and volleyball).

Considerable research has been conducted about the stages in the development of an effective group and about the positive influences the group can have on the individual; for example, how a group develops through stages in much the same way that a child develops into an adult in a phased or systematic fashion. A group can be stalled at a particular stage of development just as a child's development might be blocked at some stage of growth. Figure 1 illustrates that the meetings are sequenced in a way which is consistent with what normally happens during the establishment of an effective group.

In the following discussion an attempt will be made to present an example of each of the types of activities or meetings. The activities are intended to be done one to three times per week and require some specific skills and

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FIGURE 1

Four Stages of Group Development

Five Types of Meetings	STAGE I Inclusion/ Membership	STAGE II Establishing Shared Influence/Collabortive Decision-Making	STAGE III Pursuing Individual/ Master Goals	STAGE IV Self-Renewal: Adapting to Change
Involvement	XXX			
Rules		XXX		
Thinking	XXX	XXX		
Hypothetical Problems		XXX	XXX	
Real problems Solving		XXX	XXX	XXX

Figure 1. Relationship of the Five Types of Meetings to Stages of Group Development

procedures for effective leadership. Some of the skills pertinent to each type of activity will be included in the discussion.

Involvement activites. The goal of these activities are to help the students become friends with each other and with their counselors, to promote mutual trust and to establish a sense of belonging. The participants are encouraged, but not forced, to share information about themselves and subjects familiar to them. It might be said that people do not grow in a hostile environment! One assumption is that each person should have at least one person in the dormitory who likes him or her. One of the favorite activities used as an involvement activity is called "What Is Your Bag?" Participants are asked to make a bag using a grocery bag, magazines, scissors, and paste. The bag is to be decorated on the outside with pictures that show how most people see you. Pictures are placed inside the bag to represent "how you think you really are." In other words, the outside of the bag represents the image the student presents to the outside world, and the inside of the bag represents the image the student has of himself and herself.

When leading an activity like this it is important for the leader to allow the members to proceed at their own pace. Some participants may want to share only the outside of the bag. What is presented should be accepted by the leaders in a nonjudgmental manner and members should be encouraged to listen carefully and to ask useful questions. It is usually helpful if the leader and group establish some rules for the discussion of the bags. Two useful rules are, "No put downs" and "Listen to each other."

Rules Meetings.   Rules are not only useful for conducting group discussions, they are also valuable for developing a positive atmosphere in the dormitory and outdoor play areas. Rules meetings involve the students in theformation of standards of behavior and thereby insure greater cooperation. The assumption is that students will have a better attitude towards rules that they have some voice in determining. There are, in actuality, two forms of rules meetings. One type of meeting is designed to help the students become familiar with the rules which have been predetermined by the school authorities. It is important that the students be aware of the rules and know the consequences for violating them. It is usually effective to lead a discussion about why the rules were established and why the rules are helpful to the group. If the rules are fair most of the group will support them.

A second type of meeting focuses upon the rules that are left to the counselor's discretion. Examples are those rules which apply to the counselor's interactions with the students or the standards needed for a particular wing of the dormitory. In rules setting meetings, rules are determined cooperatively by the counselor and students. One question is, how many rules are needed? Rules should be kept to a minimum of five to seven because more than that is difficult to remember. (Note the number of people you know who can recall every one of the ten commandments.) When the counselor and the group brainstorm for rules they will come up with a large number, usually 20 to 30. In order to bring this number down to size the counselor can ask the group to reduce them by looking for similar or overlapping statements. The counselor has the final authority about the rules and can reduce the list to a manageable number. A second meeting at which the group members agree to the rules is usually constructive.

There are some areas which the counselor, by virtue of experience, can identify potential problems. These rules might best be stated as "my rules," and presented to the group as the counselor's "bottom line" regulations. In review, the counselor conducts a meeting about the school rules, and plans for a brainstorming meeting with the group to determine what other rules are needed. The objective is to develop a short list of "our rules," which the group agrees to follow. Dormitory residents will still violate the rules, and the counselor will still need to enforce them. Better compliance is usually obtained though because the residents are breaking "our rules" rather than a set of arbitrary rules developed by only the counselor.

One obligation that most of the dorm counselors have is to develop bulletin board displays. Members of the workshop have p anned to use the results of rules meetings as material for bulletin boards. Naturally the rules should be written down and made available to everyone. Writing them on the bulletin board, or better yet having group members prepare the display of the rules, is a good way to emphasize the rules, fill a board, and have the group involved in a relevant activity. Some groups have assumed the responsiblity for the bulletin boards for the rest of the year. Other counselors have used the product from a "What is My Bag" activity or similar activity to cover the board. When this is done the students spend a good deal of time looking over the board and, in some cases, changing them from day to day. The counselors need to remember that only public information (material on the outside of the bags) about the residents is to be displayed. Figure 2 shows an outline of a plan for a rules meeting.

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FIGURE 2

A Meeting on Rules

Identify the Topic

The question for our rules meeting is, "What rules do we need to have for our dorm this year?"

Ask for Definitions

What do we mean when we talk about dorm rules?

Personalize the Discussion and Ask for Specifics

What rules have you had in other years?
What rules do you have at home? at school?
What other places where you have been have rules?

Ask for Judgments and Agreements/Disagreements

Why do we have rules?
What are some good rules?
What are some bad rules?
What rules would you like to have for our dorm?
Do you know anybody who disagrees with you? If yes, why do they disagree with you?
Do you know anybody who agrees with you? If yes, why do the agree with you?
How many of us should agree on a rule before we make it one of our dorm rules?

Challenge the Group

Which rules will you be willing to follow?
What should we do when our rules are broken?
What are some ways people bother others?
What should we do when this happens?
Would two or more of you volunteer to list our rules on the bulletin board?

Figure 2. Taken from Thompson, C. L., & Poppen, W. A. Guidance Activities for Counselors and and Teachers. Brooke/Cole, 1979. Pages 141-42.

Thinking Discussions. The third type of meeting that is taught in the workshop is what is called a "Thinking Meeting." One purpose of the meeting is to maintain the group cohesiveness that was developed through the involvement activities. Other goals are to help the students develop the communication skills and mutual trust needed to work together as a group. The

discussions are conducted in an informal setting and require that the coun-selor use some specific questioning skills. The topic for discussion needs to be clearly identified and clarified. The leader must know how to personalize the conversation, how to ask for agreements and disagreements and how to challenge the group. The discussions need not come to any consensus or group decision because it is better if the thinking meetings are ended when there is still considerable disagreement and discussion. The idea is to develop topics that the group members can continue to think about and discuss with others.

How the topics for discussion are stated is extremely important. "What if . . ." is a good beginning for the topic statement. Nearly any "what if" question about a subject of interest to the group members will provoke com-ments. Some examples are, "What if football were abolished?" "What if someone offered your dorm wing $500 if you could avoid watching television for a month?" "What if you knew the time of your death?" The kinds of questions to ask during the thinking discussion are the same as those illustrated in Figure 2 (A Meeting On Rules). After a few of the meetings have been con-ducted the students can be asked to give their ideas about the topics for discussion. The counselor should make the final selection of the topics though because it is very hard to lead a discussion if the topic is considered too sensitive by the leader. For example, the members of the group may want to talk about abortion but the counselor will be ineffective if he or she has a very definite opinion about the topic and cannot tolerate the expression of some different points of view. The meetings should be kept short! Twenty or thirty minutes is usually enough for a good sharing of opinions by all group members.

Hypothetical Problem Discussions. The fourth type of meeting is called the hypothetical problem discussion. The purpose of these meetings is to con-tinue the group's development as a group. The group needs to learn skills for identifying and solving problems. The hypothetical problem meetings can be thought of as a forerunner to the problem-solving meetings in which matters directly involving the dormitory residents will be considered. When students are involved in the discussion of an actual problem, emotions are usually high; therefore learning the problem-solving process and skills may be blocked or hindered. Conversely, when responding to a hypothetical problem students can concentrate on the process and skills used to clear up problems.

Through the hypothetical problem meetings, the students should become familiar with the first four steps of the problem-solving process. The steps are: problem identification, determining alternatives, predicting the pros and cons of each alternative, and deciding on the best solution to try. Students are taught to use brainstorming methods in order to come up with a list of alternatives. Another procedure which is very suitable for doing problem-solving discussions is open chair role-playing. A difficult task in group discussions is maintaining group involvement while one or two of the members are engaged in role-playing. Some students are reluctant to role-play if they are only one of two role players. The open chair method engages six members in the role-play at the same time. When properly used, this activity can help the group focus on hypothetical problems and learn about the problem-solving process.

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The purpose of problem-solving meetings is to find ways to deal with group or individual problems that are interfering with the social environment of the dormitory. Both the hypothetical problem and the real problem-solving meeting follow the same process except the real meeting adds two st᷂s to the process. The steps are: (1) implementing a solution, and (2) evaluating the success of the solution. In other words, a commitment is made to do something about the problem.

Four questions have been found useful in helping groups or individuals consider what might be the effects of an alternative. The questions are: (1) What are the effects on you? (2) What are the effects on others? (3) How will you feel if you do this? and (4) How do you think others will feel if you do this? The first two questions deal with the tangible effects while the last two questions relate to intangible aspects (Wheeler & Janis, 1980).

In review, these are the five types of activities and meetings taught in the workshop. The inter᷂ion is to give the dormitory counselor a systematic set of procedures to use in establishing and maintaining an effective social environment for the residents. Students have actual practice in leading the groups. Also included are recreational experiences in playing and coaching four sports: softball, basketball, soccer, and volleyball.

Child and Adolescent Study

A third component of the childcare workshop is a two-part course focusing on the child in the 5 to 12 age group in Part I and the adolescent youth in Part II. Although it is a required course for all persons majoring in education, it is a recommended elective for all students who are planning to work with children and youth as well as for persons who are parents or are anticipating being parents. A laboratory experience is combined with the course in which trainees discuss problem-solving techniques based on actual anecdote situations collected from supervisors of adolescents of various ages including multi-handicapped deaf. These include videotaped situations and narratives of incidents experienced by dormitory personnel from their work settings.

Following completion of the "Child and Adolescent Study" portion of the workshop, the trainee is able to demonstrate the following skills:

1. The ability to distinguish between normal and abnormal physical, social, and cognitive development in adolescents;

2. The ability to tutor adolescents who have different styles of learning;

3. The ability to motivate adolescents through the use of Adlerian, behavorial, and humanistic psychology (see Figure 3);

4. The ability to use logical and natural consequences, rather than punishment, managing the behavior of adolescents (see Figure 4);

5. The ability to respond to adolescents on levels III, IV, and V of Carkhuff's model of active listening and effective helping,

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FIGURE 3

Developing Cooperative Partnership Behavior Contracts for Dormitory Use

POINT CHART

Tasks	Pts.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Bonus								

PAYOFF

 5 points:_____
 5 points:_____
 5 points:_____
10 points:_____
15 points:_____
20 points:_____
25 points:_____

FIGURE 4

A Ten Step Plan for Teaching Discipline

PHASE I — Making Friends With Your Problem Adolescent

Step 1 — L'st those things you have tried that did not work when s/he misbehaved. Take a pledge to not repeat any of these unhelpful interventions (e.g., threatening, removal of privileges, etc.)

Step 2 — Try a change of pace. Make a list of new things you might try (e.g., catching your student in good behavior, having a significant other adult at the school giving your student 20 seconds/day positive attention, etc.)

Step 3 — Have a better day tomorrow. Make a list of things you can do which cost no money but could help your student have a better day tomorrow (e.g., play a sport or game with your student, ask your student to help you with a project, feature your student in your biweekly personality of the week bulletin board complete with a big picture and positive statement (only) by the other dorm residents, etc.)

PHASE II — Counseling Your Student

Step 4 — One sentence counseling is used in step four. For example, the "could it be" questions:

    (a) Could it be that you want me to pay attention to you and you do these things just to get me to look at you?
    (b) Could it be that you want to be the boss and you do what you do just to prove that you can get your way?
    (c) Could it be that you have had your feelings hurt and you want to get even by hurting me?
    (d) Could it be that you want me to get off your back and the way you try to do this is to mess up everything I ask you to do?

Step 5 — Counseling about rules is the focus of step five.

    (a) What did you do?
    (b) What is _our_ rule about this?
    (c) Was what you did against _our_ rule?
    (d) What were you supposed to do?
    (e) What is a plan you can follow that will help you do what you are supposed to do?

Step 6 — Reality-based counseling is a little more involved.

    (a) What did you do?
    (b) How did it help you?
    (c) What could you do that would be more helpful to you?
    (d) What will you be willing to try in your plan to do more helpful behaviors?
    (e) When can we meet again to find out how the plan is working?

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FIGURE 4

A Ten Step Plan for Teaching Discipline
(Continued)

PHASE III — Isolation Methods When Behaviors Infringe on The Rights of Others

Step 7 — Isolation methods within the dormitory living area could include a secondary seating area often referred to as seat #2 or a quiet corner such as a study carrel.

Step 8 — Isolation methods outside the dormitory living area could include a time out room where a student may write a play for returning and remaining with the other residents.

Step 9 — Systematic exclusion methods could include longer term isolation for serious behaviors involving violence and severe infringement on other's rights. 'erhaps a dormitory space could be reserved for students requiring more time away from the group.

Step 10 — The final step is conference planning with the student, parents, and staff on the topic o' seeking an alternative placement and/or treatment for the student. The previous nine steps utilize most of what is known in psychology about teaching the subject of discipline. Most successful interventions occur in Phase I where houseparents try their best to make friends with the problem student.

The ten step plan is described in detail in: Thompson, C., & Poppen, W. _Guidance activities for counselors and teachers._ Available from Kinko's Copies, 1715 Cumberland Ave., Knoxville, TN 37916. The price of $12.25 includes tax, postage and handling.

6. The ability to send and receive personalized "I" messages involving: positive feedback, negative feedback, requests, refusals, and complaints.

7. The ability to teach adolescents problem-solving skills by helping them to learn how to become their own counselors;

8. The ability to conduct effective counseling interviews with adolescents.

Two examples of specific concepts taught in the course are behavior contracts and a 10 step plan for teaching discipline. A sample contract and an outline of the discipline plan are presented in Figures 3 and 4.

Follow-Up Evaluations

The childcare workshop has been evaluated by a questionnaire sent to all participants. Many times workshop participants are enthusiastic about their

TABLE 2

The Impact of The Workshop

Response	End of One Year (N=22) Percent	End of Two Years (N=8) Percent
None	0	0
Little	0	0
Some	23	37.5
Much	32	12.5
Very Much	45	50

learning immediately after a workshop only to be disappointed later when they attempt to put their learning into practice. The follow-up studies were conducted to verify the positive responses obtained at the end of the two workshops. The members of the first workshop were surveye' twice, first in November, 1984 and again in February, 1986. The participants of the second workshop also were mailed questionnaires in February, 1986. All questionnaires were identical in form.

A total of 34 questionnaires were mailed to the participants one year after their respective workshops (18 for the 1984 workshop and 16 for the 1985 workshop). Respon:es were obtained from 12 for the 1984 workshop and 10 for the 1985 workshop. Of those returned, 18 or 82% indicated that they were currently employed as child care workers.

The questionnaire contained five questions designed to gather information about the effects of the workshop. The first question pertained to the overall impact of the workshop in preparing the participant to become more effective in "your work." The results are shown in Table 2. All of the respondents indicated that the workshop had some impact by helping the participant become a more effective worker. After two years, 50% said the effect was "very much." After one year 45% indicated the workshop had "very much" impact upon effectiveness at work.

The second question asked the workshop member to "check the ideas or approaches which you are using with deaf children." These results are presented in Table 3.

The responses show that active listening was the approach used ₁'y most of the participants. Over 50% of those responding indicated use of 6 ₒf the 11 major concepts/skills taught in the workshop. The two year follow-up responses show that 9 of the 11 concepts were used for 63% of those responding.

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The third question asked the participants to rate their sign communication skills upon entering and leaving the workshop. The responses are shown for participants one year and two years after the workshop (see Table 4).

The results presented in Table 4 show the growth by participants in both expressive and receptive communication skills. The two year follow-ups show that all ratings were "adequate" and higher. Upon entrance, these people had rated "minimal" for both expressive and receptive. The post ratings for the one year follow-up for both expressive and receptive skills show that every participant gave a self-rating of adequate (5) or higher except one "3" rating. It should be noted that two deaf participants (9%) entered the program with "excellent" ratings for both expressive and receptive skills. The twenty-two below adequate pre-workshop ratings were reduced to only two for the one-year post rating.

A fourth question asked of the workshop participants on the survey was to "rate the impact of the sign language class in improving your ability to relate to deaf children with whom you are now working." The results in Table 5 show that for the one and two year follow-up results 87% and 88% rated the impact as adequate, good, or excellent. Again it should be noted that the workshop did include deaf participants who had excellent skills upon entering the workshop.

All participants said that they would recommend the workshop to others. Only 3 of the 30 responses indicated any reservation about the recommendation. At the end cf one year 82% saad they would strongly recommend the workshop to others (see Table 6).

The evaluations of the workshop are uniformly positive. The support for the experience continued for two years following the workshop. Reports obtained one and two years after the workshop indicate that the participants use the skills taught and report being more effective in their work.

TABLE 3

Ideas/Approaches Used With Deaf Children[a]

Approach	One Year (N=22)		Two Years (N=8)	
	N	Percent	N	Percent
Active Listening	19	86	8	100
Four goals of misbehavior/logical consequences	17	77	8	100
Games/Sports	14	64	6	75
Reality therapy: 10 step discipline	13	59	6	75
Involvement techniques	12	55	5	63
Rules meetings	11	50	6	75
Problem-solving meetings	10	45	7	75
Thinking meetings	10	45	6	75
Effective complaining	9	41	5	63
Contracting	6	27	1	13
Group meeting skills	6	27	3	38
Adaptions of all of above[b]			1	10

[a] members may check as many as they use

[b] write-in comment

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TABLE 4

Sign Communication Skills

One Year Follow-Up (N=22)

Rating		Expressive Pre N	Expressive Pre %	Expressive Post N	Expressive Post %			Receptive Pre N	Receptive Pre %	Receptive Post N	Receptive Post %
Minimal	1	0	0	0	0	Minimal	1	1	5%	0	0
	2	1	5%	0	0		2	3	14%	0	0
	3	5	23%	1	5%		3	3	14%	1	5%
	4	3	14%	0	0		4	6	27%	0	0
Adequate	5	5	23%	4	18%	Adequate	5	2	9%	4	18%
	6	4	18%	4	18%		6	2	9%	5	23%
	7	1	5%	8	37%		7	2	9%	7	32%
	8	1	5%	2	9%		8	1	5%	1	5%
Excellent	9	2	9%	3	14%	Excellent	9	2	9%	4	18%

Two Year Follow-Up (N=8)

Rating		Expressive Pre N	Expressive Pre %	Expressive Post N	Expressive Post %			Receptive Pre N	Receptive Pre %	Receptive Post N	Receptive Post %
Minimal	1	3	38%	0	0	Minimal	1	3	38%	0	0
	2	0	0	0	0		2	0	0	0	0
	3	0	0	0	0		3	3	13%	0	0
	4	0	0	0	0		4	0	0	0	0
Adequate	5	2	25%	3	38%	Adequate	5	0	0	2	25%
	6	0	0	0	0		6	1	13%	1	13%
	7	2	25%	4	50%		7	2	25%	2	25%
	8	1	13%	1	13%		8	1	13%	3	38%
Excellent	9	0	0	0	0	Excellent	9	0	0	0	0

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TABLE 5

Impact of Sign Language Class

Response	One Year		Two Years	
	N	Percent	N	Percent
None	2	9	0	0
Minimal	1	5	1	13
Adequate	4	18	2	25
Good	10	46	4	50
Excellent	5	23	1	12

TABLE 6

Recommend Workshop to Others

	Year One (N=22)			Year Two (N=8)	
Response	N	%		N	%
Strongly Discourage	0			0	
No	0			0	
Yes, with Reservations	2	9%		1	13%
Yes	2	9%		2	25%
Strongly Recommend	18	82%		5	63%

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SELF HELP GROUPS FOR DEAF ADOLESCENTS:
PROBLEMS OF DRUG AND ALCOHOL ABUSE

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The New York Society for the Deaf Substance Abuse Program has been operating for four years. This program is funded by the Division of Substance Abuse Services of the State of New York. The objectives of this program include: outreach to the deaf community, in-service consultation to agencies and programs, case management, and individual, group and family counseling. Broad based agency goals provide for assistance to alcohol and drug programs in order to access their programs for deaf persons.

Traditional programs and services for deaf substance abusers have been ineffective and have most often met with little success due primarily to poor communication and lack of understanding of the unique and special needs of deaf persons. The Society's community-based program has proven to be an effective model of service delivery. In this presentation we will address the issues, needs and strategies for intervention, and provision of services for deaf substance abusers.

THE PROBLEM OF DRUG AND ALCOHOL ABUSE

In order to gain an overview of the problems associated with drug and alcohol abuse among deaf adolescents, it is important to consider the disease of substance abuse and its biological, psychological and social consequences. Secondly, it is necessary to view the deaf adolescent within a developmental context, and in relation to some areas of stress that a disabled individual characteristically experiences. The problem of substance abuse is complex. It is helpful to address it from an holistic perspective by breaking down the

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biological, psychological, and social factors in order to plan treatment and rehabilitation strategies.

According to a 1981 survey reported by the National Institute of Alcohol and Alcoholism, national statistics indicate that there are 10,000,000 alcoholics in the United States, 73,000 of whom are deaf. One out of 10 persons is known to have a drug and/or alcohol problem. Within the disabled community, the ratio is estimated to be 1 out of 20. Statistics reveal that 70% of adolescents between the ages of 12 and 17 have experience with drugs and alcohol. In the last de ade, there has been much information published on alcoholism, but very little on alcoholism and the deaf individual.

Substance abuse, both alcohol and drug, is a progressive disease that has both direct and indirect consequences on the physical, mental and spiritual health, not only in the affected individual, but also among their family and friends. The body functions by maintaining a biochemical balance, and is negatively affected by chemical ingestion. When there is excessive chemical intake, it is manifested in loss of control, mental disturbance and dysfunction in all aspects of an individual's life.

Alcohol enters the bloodstream and circulates within the body in minutes. The faster it is consumed, the quicker one loses control. The body burns alcohol at a rate of approximately one half ounce per hour. Therefore, a 150 to 180 pound person having only one drink in an hour could remain sober. Inebriation begins as a feeling of happiness, then excitation, and progresses to a feeling of confusion, followed by a state of stupor, ultimately progressing to a comatose state. Long term effects of alcoholism are damage to the liver and heart, with possible stomach ulcers, malnutrition, cancer and brain damage.

Biological reactions to chemicals cause physical symptoms affecting the bloodstream and brain, robbing the body of required vitamins and minerals. These reactions have direct impact on organs, including the liver, heart, and digestive system, as well as on an individual's cognitive processes and psychological growth and well-being.

Psychological effects of drug and alcohol abuse are seen in the dramatic interruption of the development of the individual's process through what Erikson defines as the "life cycle stages." Each developmental level is dependent upon sequential growth of the stages of an individual's life in or er to achieve successful integration through the last stage of the life cyce. Socially, the impact of one's growth affects the values, laws and internal controls by which an individual lives his/her life. Drug and alcohol abuse disrupts the successful completion of development through each of these stages.

Adolescence is the period spanning the years from 12 to 18, and is characterized by physical changes that affect the glands and hormones. This period often is seen as occurring in erratic spurts, particularly with a reawakening of sexual interest. There is a profound impact on the emotional and social maturation with the adolescents' strong desire to move from dependence to independence. This emancipation is played out by denial of parental values

and a shift toward peers for feedback and support in an effort to develop a social self. It is a period of contradication and confusion, struggle and conflict, rebellion and unrest, all in an attempt to develop an identity and self-esteem. The instability of adolescence then, caused by biological changes, psychological confusion, and changes in social behavior--results in increased anxiety.

Deafness is more than a medical diagnosis, and needs to be viewed as a separate entity. It is a disability which severely affects receptive and expressive communication, often resulting in a severe language deficit. This expressive and receptive language impairment can contribute to isolation, feelings of inferiority, and has an adverse effect on the individual's self-esteem. It inhibits the development of a social self, which is gained through interaction with others, feedback, and positive familial and social involvement.

Linguistic limitation, generally imposed by a late diagnosis of hearing loss, poor education and limited communciation, compounds the lack of communication generally inherent in the adolescent stage. Studies of deaf adolescents have shown early deprivation in the formative years to impact on cognitive development and psychological adjustment. This can ultimately have a profound impact on the emotional maturity of a deaf individual.

A profile of a deaf adolescent at high risk for alcohol and drug abuse can be a result of the isolation, linguistic limitations, adolescent identity crises, and an increase in stressful situations that a deaf adolescent experiences. The anxiety and physical energy inherent during adolescence needs to be rechanneled in positive directions. What usually occurs, however, is that adults tend to minimize this period of uncertainty and stress.

Additional stress may be caused by family problems such as divorce, illness, and death, all of which are compounded by poor or little communication between the deaf adolescent and his family. Adolescence "normally" includes experimentation with popular drugs such as alcohol and marijuana. Peer pressure contributes to the use of drugs as a form of socially acceptable recreation. In addition, adolescents are often surrounded by adults who smoke and drink and then "preach," imposing contradictory standards of behavior. The stage is then set for the deaf adolescent to abuse alcohol and drugs as a relief and an escape as well as a means to gain social acceptance. Identity issues are further complicated by a need to balance the opposing "deaf and hearing worlds."

Let us examine some of the barriers to effective treatment of substance abuse. What has emerged is that alcoholism and drug abuse is a "hidden problem" in the deaf community. Due to the isolating factors of deafness, there is a stigma, a perception that alcoholism is a sin, and the view that "character weakness" is the problem. There is limited information available for deaf adolescents on alcohol and drug abuse as a disease and the language barrier often hinders the identification of those at risk. A lack of professionals trained in both deafness and addiction further inhibits the helping professions in dealing with issues and providing treatment. Fear, denial, paternalism and a lack of knowledge all combined, result in deaf individuals who are undiagnosed, untreated and uncounted.

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How do we, as professionals in deafness, attack the problem of substance abuse with deaf adolescents? What are the avenues open for treatment?

The first step is to start with early identification of hearing loss and provide families with appropriate information, referral and support to work through the process of accepting the deaf child. It is imperative to help parents deal with their disabled child and establish vital parent-child communication from the onset. Schools need to address substance abuse through education and the encouragement of open dialogue in order to develop trust between students and counselors and to begin educational and prevention programs.

Outreach to schools, recreation programs, community clubs and social groups is a vehicle to reach "at risk" adolescents. These efforts begin the process of providing information and understanding of the problems of substance abuse. The goal is to pave the way toward changing attitudes and views thus leading to an understanding that substance abuse is a disease. These programs can be an effective way to bridge the gap between professionals and the deaf community in a productive way. Gaining support from deaf community leaders is key to effective work in the area of substance abuse.

In working with deaf adolescents and substance abuse, several areas need to be addressed. Children who are at high risk exhibit telltale signs such as poor school work, lethargy or changes in behavior which help in early identifiction. The need to engage adolescents to "talk" about the differences between the typical developmental stresses of adolescence and drug related problems is paramount. Deaf children of alcoholics should be directed to a group, such as those patterned after Alanon. Techniques in active listening, decision making, problem solving and ways to change coping patterns are effective means to help adolescents avoid substance abuse.

Working with deaf substance abusers requires a multidisciplinary approach combining education and treatment. Modification of materials used by the hearing population is necessary in order to make concepts relevant and terminology accessible in American Sign Language (ASL). Presentation of information should be "action oriented," not solely focused on "talk." Techniques for saying "no," discussion about independence and responsibility for oneself can be demonstrated through role-playing in small groups. Professionals working with deaf adole cents need to possess fluency in ASL, understand the psychosocial aspects of deafness, and have knowledge of alcoholism and drugs. Linkages from within the community are essential to provide resources for treatment and aftercare.

The model established by the New York Society for the Deaf to develop linkages with existing community programs, provide case management, and offer support services to agencies as well as individuals, has proven to be an effective means for meeting the multiplicity of needs for serving deaf adolescents who are "users" or "at risk."

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GALLAUDET'S STUDENT DEVELOPMENT APPROACH TO SUBSTANCE ABUSE EDUCATION AND IDENTIFICAT:ON/TREATMENT

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Gallaudet College has adopted a student development-wellness approach to combat substance abuse on campus. Student development Is a philosophy that reflects areas In a student's life that change and develop during the college years. It Is the application of human development theory, principles, and practices on the postsecondary level (Miller & Prince, 1976). Since the early 1900s, educators have expressed a desire to educate students In non-academic curriculums. By Incorporating a student development philosophy, a college experience becomes broader and the total growth of the student Is addressed, not just the academic part. The writings of several theorists, Including Chickering (1979), Erickson (1959, 1963), Havinghurst (1952), D. Heath (1968, 1977), R. Heath (1968, 1977), Kohlberg (1969), Loevinger (1976), Perry (1970), Sanford (1966), Gould (1972), and Sheehy (1974), provide Insights and a variety of developmental points of view Into the needs of college students.

Principles Inherent In a philosophy of student development (Miller & Prince, 1976) Include:

1) Development Is a continuous and cumulative process of physical, psychological, and social growth which can be divided Into stages.

2) Development occurs when change Is anticipated and planned for.

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3) Systematic integration of cognitive, affective, and psychomotor experiences produce the most effective development.

4) Development is enhanced when students, faculty, and staff work collaboratively to promote continuous development.

5) Development is accentuated when there is a balance between challenge and support.

Gallaudet uses a theory-based student development framework to structure the programming efforts on campus. Though the approach used is a blend of several different theories, the work of Arthur Chickering has had the most influence. Chickering (1972) identified seven vectors of development each having a separate developmental direction. The vectors consist of developing competence, managing of emotions, developing autonomy, establishing identity, freeing interpersonal relationships, developing purpose, and developing integrity. Each vector is unique. Each defines a central concern of the college student and emphasizes developmental tasks to achieve. In addition, Chickering's vectors outline the changes in self-awareness, attitudes, and/or skills which are manifestations of successful completion of that task or vector (Knefelkamp, Widick, & Parker, 1978).

Paralleling student development theory, is the movement in the United States toward wellness. Wellness is a concept that is rapidly spreading to college campuses and businesses. Wellness is a choice-a decision to move toward optimal health. It is a way of life--a lifestyle designed to achieve one's highest potential for well-being. Wellness is the integration of body, mind and spirit--the appreciation that everything one does, thinks, feels, and believes has an impact on their state of health (Ryan & Travis, 1981).

The promotion of wellness at Gallaudet is a means to intertwine all areas of a student's development. To support the concept of wellness is to support the concept of student development. Student development is the goal, promoting wellness is the vehicle to reach that goal.

Gallaudet's student development model consists of six dimensions. Each dimension is presented through a proactive wellness orientation. The dimensions of development include:

SOCIAL-   establishing mature interpersonal relationship; pro
               viding emotional support; demonstrating leadership;
               and the ability to respect other cultures and individ-
               ual differences.

PHYSICAL-   supporting physical wellness; and understanding the
               psychological and physical risks associated with the
               use and abuse of drugs.

:NTELLECTUAL- encouraging stimulating, mental activities; solving
               problems; and thinking critically, creatively, and
               logically.

CHARACTER-   forming a personal morality and identity that are reflected through one's own values and behaviors.

EMOT'ONAL-   becoming aware and accepting one's feelings; completing tasks independently; and coping with problems.

CAREER -   becoming aware of one's interest, values, and skills and how they relate to the world of work; and acquiring the necessary sk'lls for entering and advancing in one's chosen career field.

The problem of substance abuse on the college campus is both pervasive and chronic. The concept of wellness, involving optimum mental, spiritual and physical health applies directly in the battle against substance abuse and its devastating effects on the individual. In a comprehensive substance abuse education and rehabilitation program, the TOTAL student must be addressed. It is difficult, within a student development framework, to only focus on the physical effects of drugs without addressing the peer pressure involved and support needed in recovery (emotional development); the morality of abuse and values clarification (character development); the knowledge of drug facts (intellectual development); the effects of the use of drugs on relationships (social development); and the need for future goals and life planning in avoiding the need for drugs (career development).

The key to Gallaudet's proactive and rehabilitative substance abuse services is the use of student paraprofessionals. While the concept of students helping students is an ancient one, the rise in formal well-structured student paraprofessional programs is now widespread in the educational setting. In a poll of 200 counseling center directors in 1983, Salovey and D'Andrea (1984) found that of the 156 who responded, 78% reported some kind of active peer counseling program. Ender (1984) in a discussion of paraprofessionals in the area of student affairs found that while the percentage of colleges reporting some form of student paraprofessional program remains about the same over the last 10 years, the variety of programs where students are now working has increased.

Several reasons are recognized for the effectiveness and increased use of paraprofessionals on the college campus. According to a review of the literature of the 60s and 70s, Durlach (1979) reported that in many situations peer paraprofessionals were only slightly less than or equally as effective as trained professionals in providing assistance to others. While others have objected to Durlach's interpretation of these findings (Nietzel & Fisher, 1981), there is a general agreement that in some structured instances students are equally potent as professionals in assisting other students with specific problem behaviors. Although counseling and psychotherapy and process-oriented functions remain in the realm of the trained professional, counseling center directors polled only seemed to vary on the areas that paraprofessionals are used by their centers. In a 1975 study, Crane et al., cited four main areas that paraprofessionals are used: freshman orientation, study skills, college adjustment, and drug problems. Salovey and D'Andrea (1984) indicated that while drug problems have dropped from the list of primary uses of paraprofessionals, areas such as minority students, women, career and general

psychological counseling have increased. The reason for the popularity of student paraprofessionals is that students seem to feel more at home with other students. This is because a close similarity of the student and counselor in terms of age, gender, and minority group if any, can increase a sense of trust and mutuality between the two. Studies also indicate that students who serve as paraprofessionals benefit from the experience, both in terms of valuable skills development in helping fields and in personal growth (Easton, Platt, & Van House, 1985).

Certainly, at Gallaudet, as we work within the student development framework, the paraprofessional programs are conducted with a twofold approach: first to offer increased services by peers to students, and secondly to enhance the development and personal growth of those students who apply to be peer counselors and educators through individual and group supervision. In a sense, the program offers the ability to give different levels of training to meet the varying needs of students as they progress through their college years and their own developmental maturity.

Finally, in light of budget constraints, government grants disappearing, and fewer staff positions, student paraprofessional programs are a cost-effective way to offer more services to a larger number of students (Easton et al., 1985). In the interest of retention, being able to offer new direct services through such residence hall programs provides students the opportunity to have readily available information in their daily environment and may ultimately keep students in school longer.

EDUCATIONAL/PREVENTION PROGRAMS

A key factor in student development theory is that students develop at different rates in areas of personal growth. Thus, the most effective way to present materials is in a multi-format or multi-modal fashion (Lachance, 1985). Since no one activity or program will interest or reach all students, a variety of offerings and opportunities ensures that the most information can be obtained by the maximum number of students. The educational/programming efforts at Gallaudet try to achieve a multitude of approaches to substance abuse education.

Project Stride Miniversity. Project STRIDE is the umbrella term used to describe all of Student Affairs educational efforts in substance abuse. The word 'stride' means to 'step forward.' The programs and activities of Project STRIDE help students 'step forward' in their knowledge of substance abuse.

The University Center sponsors the Project STRIDE Miniversity each October. The Miniversity is a series of drug education workshops open to all students and is also used for training all Student Affairs paraprofessionals. Titles of workshops include: Party Planning; Hangovers: Causes and Cures; Uppers, Downers, Killerweed, Big H and You; Social Drinker? Problem Drinker? Heavy Drinker? Alcoholic? What's the Difference?; Angel Dust (PCP): The Unpredictable Killer among others. As a culminating activity for the Project STRIDE Miniversity, a contest, "It's STRIDEademic" is held. "It's STRIDEademic" uses a "It's Academic"/"Jeopardy" format to challenge groups of students in their knowledge of alcohol/drug facts learned through attending the programs of the Miniversity.

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Wellness Educator Program. With the assistance of a Gallaudet Presidental Grant, a volunteer paraprofessional position was created to assist the University Center and Student Health Service in providing wellness programming on campus. While this program enables Gallaudet to increase services to students, it is a vehicle by which students can develop and/or enhance transferable work skills as they test out career options. The health professions have not been an area that hearing-impaired students have traditionally entered upon graduation. Through the Wellness Educator Program, students with training and supervision, sample a variety of career opportunities from health services to drug education.

The major goals of the Wellness Educator Program include:

○ To train students as paraprofessionals to respond and provide continuing education concerning wellness-related issues.

○ To provide assistance to the Office of Student Development and Student Health Service in making information readily accessible to students, and to assist in the presentation of workshops given on various wellness related topics.

○ To continue to evaluate and improve upon the Wellness programs and services.

○ To encourage fellow students to actively participate in the Wellness programs by serving as Wellness Educators.

○ To offer students valuable co-curricular experiences which they can use as a testing ground for career options.

○ To provide new and interesting challenges outside the classroom through prevention and intervention activities.

Students are recruited during the spring of each year for the following fall. Because this is a non-paid position, heavy emphasis is placed on the career testing and skill development opportunties available through the program. Originally, it was thought that this position would attract younger students wanting to gain experience for future paid paraprofessional positions. Ironically, many upperclassman with years of paraprofessional work experience are applying for this program. Any undergraduate or graduate student with an interest in maintaining a wellness lifestyle and a desire to help others obtain/maintain the same are invited to apply.

Wellness Educators participate in bi-weekly, two hour in-service training sessions. In-service topics include: the roles and responsibilities of the position to specific content sessions on drug, alcohol and health issues, and visits to detox and drug rehabilitation/treatment clinics are included. The in-service training sessions are conducted by the staffs of the University Center and Student Health Service.

Wellness Educators have the opportunity to work in a variety of areas depending on individual interests. Students also receive additional training

beyond the core in-service training, if it helps them in their chosen respon-sibilities. Responsibilities that the Wellness Educators have chosen include: co-presenting Project STRIDE workshops, assisting students during a women's clinic, providing CPR and first aid training, designing educational bulletin boards, dist·ibuting wellness information, creating booths for health/wellness fairs, and sponsoring awareness activities such as distributing pledge cards and buttons before springbreak to increase the awareness of the dangers of drinking and driving.

Wellness Library. The University Center collects and maintains a central file of information on wellness and student development. The information is available for use by students, faculty, and staff. The bulk of the infor-mation in this Library focuses on alcohol and other drugs. The Library is used most often by students wanting up-to-date, accurate information for class term papers, debates or personal concerns. The Wellness Library has a variety of displays which are used during awareness days or as teaching aids during workshops.

INTERVENTION AND TREATMENT

As the Wellness Educators assist in su⸠stance abuse education, two other paraprofessional programs, the Peer Advisors and Senior Peer Advisors assist in the identification and treatment of abusers.

The Peer Advisor Program. The Peer Advisor (PA) Program is administrated by the Counseling Center and is run with the cooperative efforts of Residence Life. Members of the Counseling Center staff act as Counselor-Trainers to train each group of Peer Advisors and act as consultants for the Coordinators of Residence Education (CRE) who are responsible for the residence halls. CREs provide supervision for each Peer Advisor and their work in the residence hall. Salaries of the Peer Advisors are paid through Residence Life.

Currently, Gallaudet has four teams of Peer Advisors that work with prepara-tory and freshman students. Prep and freshman students are most at risk for alcohol/drug abuse and other maladjustment behaviors. Each team consists of 5-8 Peer Advisors.

The responsibilities of the Peer Advisors in the residence halls are to:

1. Live in an assigned residence hall and become acquainted with each student on the floor. Establish a relationship with stu-dents conducive to counseling and advising.

2. Provide appropriate information about Gallaudet facilities, ser-vices, and resources.

3. Report areas of student concern to the Professional Supervisor so they can respond to student needs.

4. Support and educate the students in the student development philosophy of Student Affairs at Gallaudet.

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5. Respond to student referrals from the Professional Supervisor.

6. Consult with the supervisor on individual student problems.

7. Meet weekly with the supervisor for consultation and training. Offer a variety of constructive suggestions and ideas to develop programs which are responsive to students' needs and are both interesting and developmentally valuable.

8. Serve as planner, sponsor, coordinator, and supervisor for floor educational and social activities.

9. Coordinate with Residence Life in areas of mutual responsibility.

10. Report directly to the Professional Supervisor and Trainer on all PA matters.

11. Perform other related duties as may be assigned by the Professional Supervisor or Trainer such as recruiting, evaluating programs and projects, continuing contacts with faculty, and representing the Peer Advisor Program at off-campus and on-campus meetings and conferences.

The recruitment of students to work as Peer Advisors begins in December for the following academic year and is coordinated by a Counselor/Trainer from the Counseling Center and a Senior Peer Advisor. The actual recruiting activities are completed by the current Peer Advisors with the exception of the interview process which also includes staff from both the Counseling Center and Residence Life. The following activities occur during the recruitment period:

1. A recruitment announcement in the college newspaper, and recruitment posters on campus (December/January).

2. An informal paraprofessional briefing is conducted in the cafeteria to generate interest in paraprofessional programs in general (December).

3. Several orientation workshops (attendance is required) are held to describe the program and to answer students' questions (January/February).

4. Peer Advisors are available for informal discussions with potential applicants.

The screening and interviewing committee consists of professional staff (one Counselor/Trainer and two Professional Supervisors) involved in the program, and two students who are currently Peer Advisors.

While there are no selection procedures that guarantee the identification of students that will be effective performers in all settings, Gallaudet has employed the following procedures:

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1. an orientation workshop conducted by current Peer Advisors,

2. a written application,

3. a minimum cumulative grade point average of 2.3,

4. students registered as Sophomore, Junior, or Senior during their Peer Advisor year.

During the interviewing process students are rated on their ability to "connect" with others; to communicate clearly (receptively and expressively); and to empathize. Additionally, they are rated on accepting and using feedback; showing motivation to work with people; exhibiting a willingness to develop in their personal growth; and demonstrating dependability and professionalism. Finally, students are sought who have the ability to be a good role model and the emotional stability to handle the pressures of the position.

Worthy of note are the Peer Advisors on the Screening Committee who are involved with the role-play situations. These Peer Advisors present a crisis situation, e.g., a suicidal student, and applicants are required to respond to the situation. Student input on the final decision of whom to hire is essential. This is demonstrated by the fact that the Peer Advisors are equal voting members on the selection committee.

Peer Advisor Training. Counselors-Trainers are responsible for implementing the training program during the preservice retreat, the three hour weekly in-services, and winter retreat. In addition, Professional Supervisors (CREs) provide weekly, 30 minute supervision for each Peer Advisor. This ongoing supervision permits the Peer Advisors to explore their feelings regarding students, their work, other members of the group, and themselves.

The first opportunity for the Peer Advisors to develop their skills and working relationships is on the preservice retreat. This retreat takes place during the summer before the first semester begins. During this six day retreat, the Peer Advisors learn about the programs's philosophy and rationale, and basic work skills (listening, reflecting, confidentiality, feedback and advising skills, and programming). The retreat additionally provides the opportunity for the group to begin the process of becoming an effective team.

Throughout the school year, required weekly three hour in-service training sessions take place. These in-services provide the Peer Advisors with training and personal growth experiences. In-services are divided into two parts: group supervision, and training. During group supervision, students are encouraged to discuss their feelings relating to work, crisis situations that they were involved with, and their relationships with other group members. During the training component of the in-service, students are trained in content areas that will help them do their job effectively. Training areas include topics such as counseling/advising skill development, first aid, study skills, time management, crisis intervention, suicide prevention/intervention, sexuality, birth control, drug and alcohol education, and student development

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programming. Training modules are developed and updated by the Peer Advisor staff on a regular basis.

During the winter retreat, the Peer Advisors have a second pre-semester week to learn more about their job and each other. During this retreat the Human Potential Seminar (McHolland, 1976) is conducted. During the Human Potential Seminar, students have the opportunity to indentify strengths in themselves and others, and to utilize them in the group.

The Senior Peer Advisor Program. The Senior Peer Advisor Program was developed to provide a more intensive counseling and administrative experience for former Peer Advisors. Similar to the Peer Advisor, the Senior Peer Advisors also go through an interviewing process with a screening committee that includes the counselor/trainer for the Senior Peer Advisor Program, a Coordinator of Residenc Education and a current Senior Peer Advisor. The criteria used for selecting new Senior Peer Advisors include:

1. Successfully and satisfactorily completing one year as a Peer Advisor;

2. Demonstrating leadership skills in the residence hall program;

3. Serving as a supportive team member;

4. Demonstrating planning and administrative skills in designing student development programs and activities in the residence hall;

5. Commitment to continuing peer counseling training with a specialization in crisis intervention and peer counseling consultation;

6. Demonstrating support of the College's Student Development Philosophy.

The 1982-83 academic year was the first year that the Senior Peer Advisor Program was implemented at Gallaudet. Their role has evolved to include a number of responsibilities, such as:

1. Working directly with and assisting the counselor trainer and CRE in planning and conducting in-service training for the Peer Advisors.

2. Assisting Peer Advisors with program planning, reviewing program plans, and helping Peer Advisors to see the relationship between programs and developmental dimensions.

3. Attending floor programs offered by the Peer Advisors to provide evaluative feedback.

4. Performing administrative tasks assigned by the counselor/trainer and/or CRE, i.e., setting work schedules, evaluating bulletin boards.

5. Serving as a member of the Counseling Center Crisis Management Team.

6. Serving as a resource for Student Affairs units and other campus programs, e.g., leading workshops and group discussions.

7. Helping to educate students in the student development philosophy of Gallaudet.

Senior Peer Advisors also attend two retreats. The first being the summer retreat, one week prior to the Peer Advisor's retreat, which prepares them for their participation in the training of the PAs. However, during this retreat the Senior Peer Advisors also begin training for the Crisis Management Team and to begin developing a team spirit and strong working relationship.

The winter retreat allows Senior Peer Advisors time to renew and strengthen their bond and team work. At this time, students participate in Advanced Human Potential Seminar (McHolland, 1976) which focuses on developing a positive self-concept and in becoming proficient in conflict management and resolution.

To assist in training, Senior Peer Advisors attend the weekly in-service meetings with their Peer Advisor group. In addition, they attend their own in-service meetings. This in-service, as with the PA in-service, consists of group supervision and skill development. Topics include intensive counseling skill development (D'Augelli, Danish, Hauer, & Coner, 1980), the concerns of multihandicapped students and sexual assault, among others. In addition to the in-service training, students receive weekly supervision as needed from their Senior Peer Advisor counselor/trainer, and weekly 30 minute individual supervision from their Coordinator of Residence Education.

Both Peer Advisor and Senior Peer Advisor Programs have proved to be an invaluable asset to Gallaudet in assisting students in all dimensions of student development. Most importantly, these programs have assisted students with substance abuse problems that may have otherwise been overlooked if not for the work of these paraprofessionals.

While Gallaudet relies heavily on campus paraprofessionals to assist in educating students about substance abuse, it also trains them to refer students to campus services. In addition to supervising paraprofessionals, the Counseling Center works in conjunction with the Student Health Service in offering treatment to the student who is identified with a substance abuse problem.

The Counseling Center. The Counseling Center is staffed with both Ph.D. level psychologists and mental health counselors with an M.A. in counseling. The staff offers both short and long-term individual treatment and a variety of other therapeutic modes (i.e., group, couples, and family).

Counselors vary in their approach to substance abuse. In general, however, substance abuse is treated as one aspect of the person's total mental health picture.

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As a support to psychotherapy, Gallaudet keeps a listing of community AA groups--with interpreters--that students with substance abuse problems can attend. The counselors also have established a close relationship with a private psychiatric hospital which has a chemical dependency unit. Thus, in t. event that inpatient treatment and detoxification is necessary, the placement is made with sensitivity to deafness and where in-service training to the staff has been provided. The Counseling Center is hoping, in the future, to develop a more specific behaviorally oriented monitoring and treatment program for substance abusers.

The Counseling Center has recently started an Adult Children of Alcoholics (ACOA) group. The group is offered once a week and provides support for students who grew up in an alcoholic family.

Student Health Services. The student Health Service seeks to provide quality health care to the Gallaudet community, and is committed to educate the students in good health care concepts. This is done through health assessment of the individual and campus community, primary medical care, emergency service, and health education. A close relationship is maintained with the rest of the college community and off-campus care and social services for coordination and consultation. The Student Health Service is staffed by physicians, physician assistants, nurses and licensed practical nurses. Student Health Service plays an important role in promoting wellness and in providing support, guidance and expertise for students having substance abuse problems. Through the Student Health Service, AA meetings are offered on campus twice a week. These meetings are open to both students and staff. One closed AA meeting is offered which is also available for family and friends to attend. These groups, in addition to interpreted community AA meetings, offer at least some alternatives to students in the AA treatment model.

There are a multitude of approaches a college can take in confronting substance abuse on campus. Gallaudet, following a student development/wellness philosophy, makes use of its most valuable resource, students, in providing proactive educational and rehabilitative services. With professional supervision and guidance, these student paraprofessionals extend the network of concern we all share in providing opportunties for a lifestyle of wellness, free of the need for alcohol and other drugs.

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REALITY THERAPY AS AN INTERVENTION
FOR DEAF ADOLESCENTS INVOLVED IN
ALCOHOL AND DRUG USE AND ABUSE

JERRY EDELWICH
PAT ARRE

Reality Therapy, developed by Dr. William Glasser, is a straightforward therapeutic model. This behavioral, cognitively oriented therapy focuses on present behaviors and allows clients to find ways of fulfilling basic psychological needs without depriving others of the ability to fulfill theirs. Reality Therapy is favorably applicable to the deaf adolescent. It emphasizes the strengths within the client and what they are capable of doing now to live more constructive lives. It is advantageous in that it is a relatively short-term teaching therapy. The client is confronted with his present behavior, and the necessity of evaluating it, forming value judgment regarding it, making a plan of action for change and a commitment to follow through.

Reality Therapy is based on the following assumptions:

1. The severely disturbed, the substance abuser and the offender are suffering from the same malady; that is, they are unwilling to accept full responsibility for their behavior.

2. No treatment can occur in any situation until a person is willing to take responsibility for his or her own behavior and resolve to do better.

3. In contrast to conventional therapy, in Reality Therapy, the client assumes the responsibility for determining treatment goals. Acquisition of insight is not deemed necessary for

behavior change. The therapist's job is not to provide
excuses, explanations or justifications for irresponsible
behavior.

4. Involvement with the client is essential, in fact, synony-
mous with motivation for the counselor. Reality Therapy
rejects the traditional concept of mental illress, deter-
mining it to be evasion of personal responsibility. Each
individual is encouraged to focus upon and evaluate the
quality of their current behavior, and having formed a value
judgment, to determine whether it is leading to autonomy and
success. Thus, behavior is the focus of therapy, not
insight or unconcious motivation.

Reality Therapy accepts no excuses in the attempt to shift responsibility
for current problems on another person or set of circumstances. Because of
Reality Therapy's insistence on behavioral accountability, an individual's
deafness is not accepted as an excuse for failing values or behavioral stan-
dards. Regardless of the restriction the handicap provides, the individual
must decide if the behavior is getting him what he wants at that time. Often
with a deaf individual, there is a tendency to become overly self-involved
with the limitations of his deafness. This precludes the individual's
learning more responsible ways to live.

Involvement is the foundation of Reality Therapy. For this reason,
Reality Therapy is an extremely effective therapeutic model to use with the
deaf adolescent. The developing adolescent is vulnerable because he must
depend on his environment to help shape himself. His deafness provides addi-
tional stress and obstacles in his attempt to join the mainstream of society.
The job of the therapist is to become involved with the client, serving as a
role model and guide to help him realistically appraise his own behavior.
Often, the deaf adolescent has not yet developed the self-worth to continually
market himself, and adjustment efforts are often forfeited in a seemingly
intolerant society. Involvement with the therapist provides a means to
develop needed social contact.

The therapist, through his sincerity, warmth, concern and interest conveys
to the client belief in his abilities to make changes and develop a success
identity. Through the personal involvement with his therapist, the client
learns that life has more to offer than focusing on failure, self-imposed iso-
lation and irresponsib e behavior that perpetuates his problems. As the
client/therapist relationship develops, the patient develops confidence to
make new, lasting involvements of his own.

To be an effective role model, the therapist must be honest and set rea-
sonable limits upon the amount of time he is able to spend with the client.
It is the therapist's job to point out to the client that relationships are
available to him ith others if he would only choose to look.

With Reality Therapy, the relationship extends to examine a wide area of
interests and values. In conventional therapy, clients are encouraged to
acquire insight concerning their past behavior. This gives the client a way

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to validate and perpetuate past failuie. In Reality Therapy, this is seen as a grave error. It is certainly tempting to listen, to the client's urgent complaints. However, if behavior change is not initiated, his pain will return and he will grow disillusioned with therapy.

An obstacle the therapist must be aware of is the tendency for deaf clients to run away from involvement. The deaf client interprets his isolation and lonely experience as being the fault of others (rejection), rather than being his own choice. In truth, they have rarely given others the opportunity for involvement with them, nor have they taken the risks or extended themselves to gain friendship. The therapist's persistence and warmth helps the individual understand that he can replace his isolation with involvement.

In any therapeutic situation in which one person tries to help another live his life more successfully, change and success will come only if the person being helped is aware of what he is doing presently. In addition to the involvement outlined in Step I, consistent confrontation by the therapist helps the client become aware of his own ongoing behavior. A client will often avoid facing his present behavior by focusing on his feelings. Emotions are important to everyone, however, it is not possible to significantly change one's feelings without first changing the behavior. Emphasis is placed on present attempts at successful living. The past cannot be changed and discussion of it is not excluded, but past events are always related to present behavior. The therapist concerns himself with the positive aspects and primary character building experiences of an individual.

It is important to keep in mind, that from an early age, deaf children are taught that they are different. Parental attitudes play a big part in self-image development. A majority of deaf children who are sent to residential schools attend for at least 8 of the 12 school years. They are taught that they are "below par" because "hearing people are better," and develop lowered expectations. Attention has to be paid to this lifetime of "brainwashing." Also, deaf individuals are just as prejudiced against the hearing as the other way around. The deaf individual often because of his low self-esteem, identifies himself as a failure. This leads to antagonism, pain and withdrawal. The resultant self-involvement, which is an effort to reduce pain, keeps him from risking involvement or developing necessary social skills.

To help the client examine his own behavior and choose a new behavior, we, as therapists, must ask "What are you doing now to get what you want?", "I understand how you feel, but what are you going to do?" It is important to identify the behaviors the client is engaging in at the present; specifically, day by day, situation by situation. When examining behavior, resistance and compensation are common. It is necessary for the therapist to be confrontive and continuously point out the consequences of present behavior. Thus, the individual's symptoms are related to his behavior, and activities that reduce symptomology are encouraged. Although a client's behavior may be unrealistic, irresponsible and inadequate, it is still an attempt to fulfill their basic needs of being loved and of feeling a sense of self-worth. The behavior is an attempt to gai sense of identity.

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Clients are challenged to take a critical look at their lives and make value judgments regarding the effectiveness of their behavior in attaining their life goals. The therapist does not judge the client's behavior; but rather, leads the client to evaluate his own behavior by bringing it out for examination. An individual must truly desire and value a change of situation before any self-defeating behavior can be worked on. The therapist moves his client towards a value judgment by asking the following types of questions: "Is what you're doing getting you what you want?", "Is your present behavior a realistic way to achieve your goals?", "Is what you are doing helping?" (evaluate effectiveness of behaviors). Examining behavior in this manner is often uncomfortable. Admitting that behavior has been self-defeating or irresponsible is, in the mind of the client, admitting failure. It is important then, for the client not to be excessively self-critical and to direct his criticism at those activities which are possible to correct. Excessive self-criticism may conceivably lock the client into failure by overwhelming him with his past failures.

The client's formation of a value judgment is the most critical step of the therapeutic process, providing the foundation for change and plan implementation. Following a value judgment, realistic plans for action and change are formulated.

In plan development, the therapist becomes a resource person, for irresponsible or failure identities often have no experience in planning for a successful life. Development of a plan for change must be specific, action-oriented and workable. A plan which attempts too much at once, usually fails and only serves to reinforce present failure. For this reason, the format of the plan is usually a series of smaller attainable goals. Plans for change need to be in an affirmative, positive content, increasing in complexity only as success is achieved. After an individual decides on a plan of action, the therapist assists him in making a commitment to implement the plan in daily life. The therapist needs to be aware that a primary characteristic of a client who has a failure identity is that they have a resistance to commitment. A failure identity fears that if he commits himself to a plan and fails, he may experience painful rejection. The involvement discussed in Step I is crucial here, for the client must feel secure enough in his relationship with the therapist to know that the rejection will not occur. When a person does not fulfill his commitment, the value judgment which preceeded the plan must be reexamined. If the client is not truly committed to change, no plan will work.

Excuses are not accepted in Reality Therapy. The question, Why?, is rarely asked. An excuse may reduce the pain of failure, but it does not lead to success. The only commitments many failing identities have made in the past are to their irresponsibilities, emotions and self-involvement. Change cannot occur until the client is willing to reexamine his plan, renew the commitment to the plan, and follow through. A Reality therapist must not accept excuses or probe for fault. At this point, it may be necessary to revise or change the plan to make it more attainable.

Like many social attitudes, prejudice against deaf persons is partly a cultural inheritance, a legacy from past times when any kind of handicap was

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superstitiously equated with inferiority.   It is not always possible to
recognize the subtle forms which prejudice can take.   The understanding of
deafness requires more than laying aside prevailing myths concerning deafness
and communication skills, a fundamentally negative approach.   The deaf person
should be approached through a framework of common experience.

Deaf people are human beings with the same basic needs as other human
beings; the need to love and be loved, the need for security, the need to
achieve and be recognized for their advancement, the need for a successful
identity.   The potential of deaf individuals is no different from that of the
hearing, yet numbers of deaf people never realize their full potential.   For
reasons that are only tangentially related to the condition of deafness, they
isolate and cut themselves off from the kinds of communication that facilitate
a steady and natural development.

The heart of Reality Therapy is the acceptance of personal responsibility,
which is equated to mental health.   Each individual has positive assets,
values and potential which can work for him despite any prejudice he
encounters in mainstream society.   Often the deaf individual must first
examine his own prejudices, and look beyond, to what he can achieve if he is
willing to accept responsibility for success.   Within the framework of Reality
Therapy can be found self-worth and freedom through responsible living.

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"NETWORKING - THE FORGOTTEN MINORITY"

PETE ANDERSON

There is a crying need for drug and alcohol abuse treatment
for those with the whole range of physical and mental "disabil-
ities." But the vast majority of existing treatment programs,
both public and private, are effectively "closed" to people with
disabilities. With few exceptions, "mainstream" programs lack
the facilities, the staff, and even the inclination to accom-
modate disabled substance abusers. Awareness on the part of the
general public regarding the limitations that architectural
barriers impose upon disab'ed persons is really just beginning.
The technological capability to eliminate some of the barriers
already exists. This paper reviews some of the ways programs in
Los Angeles County are attempting to network to effectively
respond to the needs of disabled substance abusers.

People who have disabilities--physical, mental or sensory--are also, in
many ways, "disadvantaged" in our society. Despite some progress in recent
years, it is still true that our buildings, facilities, sidewalks, buses,
etc., present the disabled with constant obstacles. The blind and those in
wheelchairs, for example, find it very ard even to get around in the com-
munity or to use most restrooms, elevators, and other commonplace facilities.
When it comes to specialized kinds of services which should accommodate the
disabled, the situation is actually far more bleak.

Consider the problem of alcoholism and drug addiction. Treatment programs
for substance-abusers abound today. Chemical-dependency has grown to epidemic
proportions, and this is largely recognized by the general public. What is
much less widely known, however, is that people with disabilities, for a
variety of reasons, are especially prone to substance abuse problems, par-
ticulary alcoholism. The sheer difficulty of facing life every day when one
has a disability, the despondency and lack of self-esteem which may accompany

this, often physical pain, prolonged medical treatment (and, frequently, "overmedication"); these are but a few of the underlying dynamics tht lead to chemical-dependency in the disabled. Commonly, the secondary (chemical) "disability" undermines the person's capacity to overcome their primary disability and become a contributing member of society. Thus, the rearranging of alcoholism as the primary disability will enable people with other disabilities to acquire total rehabilitation.

There is a crying need for drug and alcohol abuse treatment for those with the whole range of physical and mental "disabilities." But the vast majority of existing treatment programs, both public and private, are effectively "closed" to people with disabilities. With few exceptions, "mainstream" programs lack the facilities, the staff, and even the inclination to bring people with disabilities into their midst. Thus, for the most part, disabled substance-abusers are unwanted, unwelcomed, and unaccommodated. Either the blind, deaf, nonambulatory, retarded, etc., get no treatment at all, or else, if provided with "treatment," they feel isolated within programs that are not well-equipped (and likely not well-disposed) to deal with them.

People with physical disabilities suffer from alcohol abuse, just as "able bodied" people do. Yet, the existing service delivery system is not structured to treat the alcohol problem when accompained by other physical disabilities. A corrective action plan is needed to improve this situation (O.A.P. Plan 1981-82).

Nineteen percent of all people in California between the ages of 16 and 64 have some sort of disability that substantially limits one or more life functions Nine percent of all persons in California between the ages of 16 and 64 report that they are severely disabled. There is a higher prevalence of severe disability among blacks and person of Hispanic origin--8% Caucasion, 13% Black, 13% Hispanic, 6% other. (Department of Health and Human Service based on survey taken 1977-78 of 23,668,562 people living in the State of California).

A 1980 survey sponsored by the State Department of Rehabilitation found that aproximately 248,750 people in California who have alcohol abuse problems also have other disabilities. Alcoholism is considered the primary health problem of over 74,000 of these people. Based on the State survey, OAAA estimates that there are over 82,000 people in Los Angeles County with alcohol problems and other physical disabilities; and almost 25,000 of these people suffer from alcoholism as their main disability. This population of disabled problem drinkers involves a wide variety of physical disabilities, including spinal cord injuries (para- and quadriplegic people), visually impaired and blind people, hearing-impaired and deaf people, and people with developmental disability such as cerebral palsy and epilepsy (O.A.P. Plan 1981-82).

"Our society misses a whole lot by not knowing us. I think we have so much to give to this country and we have only begun to give . . . We must dedicate ourselves to being sure that we do not create another generation of young people with disabilities who grow up to

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be dependent on their families or institutions, and on the public welfare system." (Ed Roberts, Past Director, California State Department of Rehabilitation delivered as a part of his 1980 presentation to the President's Committee on Unemployment of the Handicapped, Washington, DC).

While 1981 was the "International Year of Disabled Persons," the fact remains that despite federal legislation and mandate, equal access to alcohol and drug treatment facilities does not exist for many people with disabilities. Human Service providers are not familiar with the culture and unique needs of the physically disabled, and are frequently uncomfortable in dealing with disabled clients (Boros 1979; Lowethol & Anderson, 1981).

While working for the Veterans' Administration Spinal Cord Injury Service, Drug and Alcohol Treatment Program in Long Beach, California, Pete Anderson, Executive Director, Disability/Substance Abuse Task Force, Inc. observed with other staff professionals that at least 75% of the spinal cord injury admissions were a direct result of drug and/or alcohol abuse. James O'Donnell, Ph.D., who works at the Maryland Spinal Cord Injury Rehabilitation Center says that "between 50% to 60% of their new traumatic spinal cord injuries are a direct result of chemical addiction." On the other hand, as a means of coping with one's disability, one may turn to alcoholism. Dr. Larry Stewart, Ph.D., who is deaf himself and was the Director of Community Mental Health Services for the Deaf (CMHSD) in Orange County says "that among clients at CMHSD, approximately 25-35% were noted to have significant problems associated with alcohol and/or drug abuse!"

<u>People with disabilities are more likely to be hospitalized</u>:

> In 1977 about 25% of severely disabled and 14% of partially disabled people were hospitalized compared with only 2% of the non-disabled population. Median income for severely disabled persons is half that for non-disabled. Approximately 25% of severely disabled persons exist below the proverty level (survey 1977-78 ibid).

What do these statements say to you? They are telling us that if we begin to look at the alcohol use and abuse patterns of these people we may find out that a significant number of hospital admissions are not caused by medical problems related to their disability, but rather medical problems caused by alcoholism. <u>We need to train our medical professionals and paraprofessionals to look beyond the apparent physical disability to the more subtle disease of alcoholism. We are going to have to help them understand that their job is not over just because they detected the substance abuse problem. They also must learn to confront the clients and help them realize their addiction or at least to get these people to Human Service Providers that will refer the disabled substance abuser to an agency that is sensitive to their needs.</u> We are losing a lot of money as well as valuable lives and resources. Unless we begin to confront the real problem, these losses will continue.

The above quotes on disability are not what they may appear to be. People with disabilities who do not abuse chemicals usually hold responsible jobs and

positions in the community, the same types of jobs and positions any non-disabled person would hold. However, when alcohol or other drug abusing behavior takes control in the disabled person's life, they become unemployable and uninterested in the community that they could contribute to. Alcohol affects the person who has a disability the same way that it affects people who are "temporarily able-bodied" (TABs); it debilitates them.

Rehabilitation of a physical disability such as blindness, deafness, spinal cord injury, etc. will never occur as long as that individual is abusing mind altering substances. In the rehabilitation of a disabled substance abuser we have to look at the primary disability, which is alcoholism.

Department of Labor statistics (1977-78) show: "That for every $1,000 invested in the rehabilitation of someone with a disability, $35,000 will be generated by that person during their lifetime, part of which goes to federal and state taxes. Ever more impressive, it is estimated that the employment of 100,000 people with disabilities in the United States adds at least $500 million dollars to the GNP; and people with disabilities who are economically independent do not burden community public assistance funds." This is why we so vitally need to open up the present Alcohol Service System to people with physical, sensory and mental disabilities.

"Yet it was found that 29% of disabled persons admitted into an independent living project were dysfunctional due to alcoholism and/or drug abuse." (Ed Imai, CSULB Conference, April 15-16, 1981).

Yet, here in mid-1985 we still find very little being done to save the tax payer of the State of California money by providing this very valuable rehabilitative service.

Many barriers are scarcely noticeable to non-handicapped persons. Obviously an office building housing an alcoholism agency, which may only be entered by climbing a flight of stairs, is inaccessible to a person confined to a wheelchair seeking services. A building which has a ramp to the entrance, but which has no restroom cubicles wide enough to accommodate someone in a wheelchair, is also inaccessible. Low hanging signs or light fixtures in hallways (which those with sight can avoid) are physical barriers to the blind, and people who are deaf cannot readily negotiate in a building where auditory warning devices are not used in conjunction with corresponding visual indicators. Or how do service providers know when someone who is deaf is trying to acquire alcoholism services, when most service providers in the field do not have TDDs (Telephone devices for people who are deaf or hearing-impaired)?

Awareness on the part of the general public regarding the limitations that architectural barriers impose upon handicapped persons is really just beginning. Yet the technological capability to eliminate some of the barriers already exists.

At the present time, equal access to treatment facilities and counseling centers do not exist for many people with disabilities. Wheelchair ramps, specially designed restrooms, lowered drinking fountains and telephones, signs

and pamphlets in Braille, service providers proficient in sign language are not present in many centers designed to aid those with alcohol problems. These people "fall between the cracks" in the parlance of service providers. The person who, in addition to a problem with alcohol, happens to be deaf has nowhere to turn. The agency serving deaf persons does not know how to treat the alcoholism and the agency where others can go for help with alcoholism must deny him/her the full benefit of their services because they cannot communicate with him/her having no interpreter. Section 504 of Public Law 93-112 is an attempt to rectify that unfortunate situation at least in agencies that receive funding from federal sources. This section recognizes that the disabled have a right to services provided to the community at large and further recognizes that "separate but equal facilities" may not always be in the best interests of the clients. Compromises may have to be tolerated, at least at the onset; many agencies are run on a shoestring and to require them to redesign their buildings may prove impractical in terms of utilization of financial resources. Perhaps a compromise could be in the form of one agency in a geographical region being made accessible to serve segments of the disabled population would be more practical.

At the state level we have similar legislation in protecting the right to state funded services for people with physical and/or mental disabilities. This bill, AB 803, was authored in 1977 by the present Speaker of the California State Assembly Willie Lewis Brown (see Appendix A).

Recovery homes are denied permission to serve the disabled because of ordinances that require sprinkler systems and other renovations that would in effect close down the facility to everyone. Let's not be too quick to throw the baby out with the bath water. Rather, let's increase access to all, including the disabled, without diminishing the quality of services for the entire community. We need to find ways of rearranging these laws and regulations for the benefit and safety of all. We agree that there is a need for effective fire regulations that protect people with disabilities from serious harm. However, it could also be said that those same regulations which are designed to protect the lives of people with disabilities are also contributing to their demise. People who are not given the opportunity to enter treatment are thus sentenced to be institutionalized with no hope of re-entry to the community or to die for lack of the required services for their alcohol related problems.

In the past year the O.A.P. consultant on disability has conducted on-site investigations of Los Angeles County supported alcohol abuse treatment programs, examining the capacity of these programs—in terms of both staff and facilities—to handle the needs of disabled alcoholics. The results are most revealing. Out of 100 such programs, all but a few lack even basic "access" for those in wheelchairs. Few are equipped to work with blind or deaf persons. None has extensive experience dealing with disabled alcoholics, none offers anything like a truly optimum setting, none are able to accommodate a wide range of disabilities. And, of course, none are targeted specifically for the disabled community. Furthermore, it should be noted that the Los Angeles County authorities are more enlightened than most in this field—as evidenced by the fact that they commissioned this particular survey. The problem is even more intractable, and the programs even less available to the disabled, within private sector treatment facilities.

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The fundam   ti diffi..u'ty is twofold. First, those who operate many of
these programs   ally don't want to be "bothered" by the presence, and special
requirements, of the disabled. Second, the general feeling is that the cost
of bringing facilities into line with the needs of the disabled, and of main-
taining appropriate staff (those who can both speak and use sign language, for
instance) is truly enormous. Providing treatment for disabled alcoholics on
an occasional or irregular basis in existing programs-(while it is a laudable
long-term goal)-may simply not be a practical and/or "cost-effective" short-
term goa'. This is an overwhelming obstacle, even for those who are willing
to serve the disabled--especially at a time when public funds for such ser-
vices are dwindling.

WHAT IS BEING DONE IN LOS ANGELES COUNTY TO ADDRESS THIS PROBLEM?

In 1981 the County Alcohol Program office began to look at this problem in
a systematic way. Some of the issues that came to be recognized at that time
were:

O.A.P. became aware that service providers did not outreach to people with
disabilities as was done with other groups of people in need of alcoholism
services.

There was a new awareness relative to a real lack of mainstream transpor-
tation needed by people with disabilities, who were trying to get to programs
that may accept them for alcoholism treatment

The people from the County Alcohol Program office who were looking into
this new problem area were becoming more aware of the role of structural
barriers in county funded programs and how this lack of access was in fact
keeping a whole group of people out of the service system. They were also
recognizing the need for training in this area; there was a new awareness that
attitudinal barriers could be more devastating than the physical ones.

Another interesting phenomenon was the realization that people with disa-
bilities were experiencing many of the same problems accessing services as
other minority groups had in the past, the big difference here are the physi-
cal barriers to treatm

Back in 1981, there was a realization that the county had routinely com-
piled client admissions and departure data relative to the client's age, sex
and ethnic makeup. However, there had never been any of this documentation
done in the area of physical, sensory or mental disability.

Also for the 1981 county alcohol plan there   was a comprehensive
"questionnaire on community needs to service agencies and organizations
throughout Los Angeles County."   In this questionnaire there were two
questions on disability.

Question #1: Do you think that existing alcohol programs in your
community should be made accessible to alcoholics who have other
disabilities? Eighty-three percent of those who responded to this
question said, "Yes, programs should be accessible for people with

disabilities;" 6% said "No, that programs should not be accessible" and 10% of the people who responded had no opinion.

Question #2: Do you think that alcoholics with other physical disabilities need special programs? Here 56% of the respondents said "Yes, that special alcohol treatment programs for people with disabilities were needed;" 26% said "No, special programs were not needed" and 18% did not comment either way.

Accordingly, with the data from these two questions and other information that was acquired at that point in time, the feeling was to support the notion of making existing programs more accessible for people with disabilities. That decision was pretty much consistant with input from leaders in the movement of substance abuse services for people with disabilities. However, as we look at this problem more intensely three to four years after the above notion was generated we may also wish to reevaluate it. For example, a possible short-term goal with positive long-term implications could be the development of a specialized multi-service treatment program for the specific needs of people with disabilities throughout the county of Los Angeles.

Some other recommendations that were made in the 1981-82 plan were:

1. Develop (pending available funding) a contract for Community Awareness/Prevention/Development focused on disabled problem drinkers. Since April 1983 the county has had a consultant who has orchestrated six regional workshops networking alcoholism, drug abuse treatment/prevention service providers with the disabled service providing community. These workshops were held in West Los Angeles, Long Beach, Sou. Central, Pasadena, San Gabriel Valley and the San Fernando Valley. The consultant has also provided numerous in-service training programs for alcohol treatment/prevention (Los Angeles County contract programs) and also for service providers in the disability community. He has developed numerous local meetings bringing together specialists in all of the appropriate fields, and he has been available to provide needed technical assistance and referrals whenever or wherever needed.

2. Survey program providers to determine the current level of program accessibility to the disabled. We have just completed a personal inspection of 100 county contracted programs checking on physical and attitudinal accessibility.

3. Develop a plan to educate program providers concerning the disabled alcoholic and appropriate treatment procedure. Ongoing since April, 1983 (in conjunction with the #1 recommendation above).

4. Evaluate client admissions and departures reporting systems and redesign these procedures to better reflect the scope of services provided to the physically disabled. This is still pending, but is still a goal of the office.

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5. Conduct an assessment of the specialized needs of various disabled subpopulations (e.g., deaf) to determine specialized needs (e.g., sign language interpretation), and develop a plan for meeting these needs. This is ongoing, but there is a good possibility that we will be doing a more detailed needs assessment within the next year.

So what is being done at the present?

1. Continued employment of a disability consultant with O.A.P.

2. Six regional networking workshops which brought together almost 500 people from the key communities we are trying to network.

    Continued technical assistance (T.A.) when and where needed.

4. Continue to look at programs for physical and/or attitudinal access.

5. Continued free in-service training on disability and alcohol related problems issues for county funded alcohol problem service providers.

6. We are in the beginning process of developing "mini" networks. These networks are designed for the sharing of resources and expertise relative to disability and alcohol related problems at the local level. For example, the Long Beach Bellflower network met n June and July of 1985 and are planning to support each other by providing mutual training experiences. They are also looking at the possibility of implementing a small networking workshop focusing on the Long Beach Bellflower area specifically.

APPENDIX A

STATE A.D.P. REGULATIONS

TITLE 9   ALCOHOL AND DRUG PROBLEMS

Register 83, No. 4-1-22-83   (p. 789)

SUBCHAPTER 6.   NONDISCRIMOMATION IN PROGRAMS OR ACTIVITIES RECEIVING STATE FINANCIAL ASSISTANCE

Article 1.   General Definitions

10800.   Definitions

As used in this Subchapter, the following terms shall apply: (a) Article 9.5. "Article 9.5" means the provisions of Assembly Bill 803, Statutes of 1977, Chapter 972. This section of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code of California (commencing with Section 11135) provides for nondiscrimination in programs or activities receiving state financial assistance and provides the legal basis for those regulations.

10805.   Purpose

The purpose of this Subchapter is to implement Article 9.5, which is designed to eliminate discrimination on the basis of ethnic group identification, religion, age, sex, color, or physical or mental disability in any program or activity receiving state financial assistance.

10807.   Application

This Subchapter applies to each recipient of state financial assistance from the Department of Alcohol and Drug Programs.

Article 3.   Discriminatory Practices Relating to All Groups Protected by Article 9.5

10820.   Discriminatory Practicas Applicable to All Recipients

(a) In carrying out a program or aci. vity, a recipient shall not, on the basis of ethnic group identification, religion, age, sex, color, or physical or mental disability:

(1) Deny an ultimate beneficiary the opporcunity to participate in or banefit from a program or activity;

(2) Deny an ultimate beneficiary an opportunity to participate in or benefit from a program or activity which is as effective or equal to that affo-ded others; to be effective said program or activity

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shall afford an equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(3) Make selections of sites or locations of facilities in which to conduct a program or activity that have the purpose or effect of excluding ultimate beneficiaries from, denying them the benefits of, or otherwise subjecting them to discrimination.

(b) The discriminatory practices set forth in Subsection (a) of this Section shall not be construed to be all inclusive.

NOTE: Authority cited: Section 11138, Government code.
Reference: Sections 11135 and 11139, Government code.

Article 9. Discriminatory Practices Relating to Physical or Mental Disability

10870. Definitions

As used in this Article, the following terms shall apply:

(a) Disability. "Disability" means any condition or characteristic that renders a person a disabled person.

(b) Disabled Person. "Disabled person" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

(c) Has a Record of Such an Impairment. "Has a record of such an impairment" means has history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(d) Is Regarded as Having an Impairment. "Is regarded as having impairment" means:

(1) Has a physical or mental impairment that does not substantially limit major life activities but is treated by a recipient as constituting such a limitation;

(2) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(3) Does not have a physical or mental impairment, but is treated by a recipient as having such an impairment.

(e) Major Life Activities. "Major Life Activities" means functions necessary to be self-sufficient such as caring for oneself, walking, seeing, hearing, speaking, breathing, learning and working.

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(f) Physical or Mental Impairment. "Physical and mental impairment" means:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or

(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(3) The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairment, cerebal palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and drug addiction and alcoholism.

(g) Qualified Disabled Person. "Qualified disabled person" means:

(1) With respect to employment, a disabled person who, with reasonable accommodation, can perform the essential functions of the job in question. The term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs preven 3 such person from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitue a direct threat to property or the safety of others; and

(2) With respect to other pi jrams or activities, a disabled person who meets the essential eligibility requirements of such programs or activities.

NOTE: Authority cited: Section 11138, Government Code.
Reference: Section 1135, Government Code.

10872. Discrimination Prohibited

A recipient shall not:

(a) Discriminate against an ultimate beneficiary on the basis of his or her physical or mental disability.

(b) Deny a qualified disabled person the opportunity to participate in a program or activity which also serves non-disabled persons.

(c) Fail to take appropriate steps to ensure that communications with ultimate beneficiaries are available to persons w th impaired vision or hearing.

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(d) Deny aid, benefits or services to a qualified disabled person because a recipient's facilities are inaccessible to or unusable by such person.

    NOTE: Authority cited: Section 11138, Government Code.
              Reference: Sections 11135 and 11139, Government Code.

10874. Program Accessibili '

A recipient shall operate each program or activity in such a manner that the program or activity, when viewed in its entirety, is readily accessible to disabled persons. This shall not be construed to mean that a recipient must make each of its existing facilities or every part of a facility accessible to and usable by disable persons.

    NOTE: Authority cited: Section 11138, Government Code.
              Reference: Sections 11135 and 11138, Government Code.